

“THE PATIENT SURVIVED DESPITE THE TREATMENT”

A STUDY OF FINNISH HEALTH POLICY AND NEW PUBLIC MANAGEMENT

Case: *The Government Resolution on the Health 2015 public health programme*

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Internationally, Finland has been among the most respected countries during several decades in terms of public health. WHO has had the most significant influence on Finnish health policy and the relationship has traditionally been warm. However, the situation has slightly changed in the last 10-20 years. The objectives of Finnish national health policy have been to secure the best possible health for the population and to minimise disparities in health between different population groups. Nevertheless, although the state of public health and welfare has steadily improved, the socioeconomic disparities in health have increased.

This qualitative case study will demonstrate why health is political and why health matters. It will also present some recommendations for research topics and administrative reforms. It will be argued that lack of political interest in health policy leads to absence of health policy visions and political commitment, which can be disastrous for public health. This study will investigate how Finnish health policy is defined and organised, and it will also shed light on Finnish health policy formation processes and actors. Health policy is understood as a broader societal construct covering the domains of different ministries, not just Ministry of Social Affairs and Health (MSAH). The influences of economic recession of the 1990s, state subsidy reform in 1993, globalisation and the European Union will be addressed, as well.

There is not much earlier Finnish research done on health policy from political science viewpoint. Therefore, this study is interdisciplinary and combines political science with administrative science, contemporary history and health policy research with a hint of epidemiology. As a method, literature review, semi-structured interviews and policy analysis will be utilised. Institutionalism, policy transfer, and corporatism are understood as the theoretical framework.

According to the study, there are two health policies in Finland: the official health policy and health policy generated by industry, media and various interest organisations. The complex relationships between the Government and municipalities, and on the other hand, the MSAH and National Institute for Health and Welfare (THL) seemed significant in terms of Finnish health policy coordination. The study also showed that the Investigated case, Health 2015, does not fulfil all necessary criteria for a successful public health programme. There were also several features both in Health 2015 and Finnish health policy, which can be interpreted in NPM framework and seen having NPM influences.

Keywords: comparative political research, government, health policy, New Public Management, non-governmental organizations, parliament, policy analysis, political parties, political systems

LIST OF ABBREVIATIONS	5
1. INTRODUCTION	6
2. AIMS, STRUCTURE, METHODS, DATA, RELIABILITY, AND VALIDITY	14
2.1 The aims and structure of the study	14
2.2 Methods and data	16
2.2.1 Semi-structured interviews	17
2.2.2 Policy analysis	19
2.2.3 Written data	22
2.3 Validity and reliability	22
3. THEORETICAL FRAMEWORK AND APPROACHES	25
3.1 Institutional theory and rational decision making	25
3.2 Policy transfer, organisational learning, and path dependency	29
3.3 Corporatism and public choice theory	32
4. PUBLIC ADMINISTRATION AND NEW PUBLIC MANAGEMENT	37
4.1 NPM in a nutshell	38
4.2 Finnish public administration and NPM	41
4.2.1 The 1990s recession and NPM	43
4.2.2 State vs. municipalities	45
4.3 Some relevant changes regarding NPM in Finland	47
4.4 Future considerations	49
5. HEALTH, POLICY, AND POLITICS	52
5.1 Health promotion and social determinants of health	56
5.2 Health and politics	58
5.3 Health policy and party politics	62
5.4 Evidence-based health policy making	63
5.5 Targets in health programmes	66
5.6 International actors influencing health	70
6. FINNISH HEALTH POLICY	74
6.1 Definition of Finnish health policy according to literature	74

6.2 Historical background and present day	75
6.3 International influence and interaction	84
6.4 Public health research, education, and funding	89
7. ACTORS IN FINNISH HEALTH POLICY	93
7.1 Ministry of Social Affairs and Health	93
7.2 The National Institute for Health and Welfare and other sector research institutes	105
7.3 Municipalities	111
7.4 Public health and nongovernmental organizations (NGOs)	120
7.5 Trade unions	126
7.6 Industry	134
7.7 Media	140
7.8 Parliament of Finland and political parties	144
8. CASE: THE GOVERNMENT RESOLUTION ON THE HEALTH 2015 PUBLIC HEALTH PROGRAMME (HEALTH 2015)	150
8.1 Programme-based policy making in Finland	150
8.2 Health 2015 and other policy programmes	153
8.3 Preparatory process	155
8.3.1 Some general observations	155
8.3.2 Participants	159
8.3.3 Objectives	164
8.3.4 Resources and communication	165
8.3.5 Structure, content, and preparatory schedule	166
8.4. Policy analysis on Health 2015 document	173
9. RESULTS	176
10. DISCUSSION	181
11. BIBLIOGRAPHY	198
FOOTNOTES	215
APPENDICES 1 -10	217

LIST OF ABBREVIATIONS

ABPH	The Advisory Board for Public Health
CS	Civil servant
CVD	Cardiovascular disease
EBDM	Evidence-based decision making
EBM	Evidence-based medicine
EU	The European Union
FMA	The Finnish Medical Association
FSHS	Finnish Student Health Service [YTHS]
HFA	Health for All
Health 2015	The Government Resolution on the Health 2015 public health programme
HiAP	Health in All Policies
KTL	The National Public Health Institute
MAF	The Ministry of Agriculture and Forestry MEE The Ministry of Employment and the Economy
MF	The Ministry of Finance
MFA	The Ministry for Foreign Affairs
MP	Member of Parliament
MSAH	The Ministry of Social Affairs and Health
NCD	noncommunicable disease
NGO	nongovernmental organisation
NPM	New Public Management
O	Other
R	Researcher
RAY	Finland's Slot Machine Association
SDP	Social Democratic Party
SOSTE	Finnish Society for Social and Health
STAKES	The National Research and Development Centre for Welfare and Health
TEC	Treaty establishing the European Community
Tehy	The Union of Health and Social Care Professionals
TEU	Treaty on European Union
THL	National Institute for Health and Welfare
TK/TK21/TK2000	Health for All [Terveystä kaikille]
VALSU	The national plan for organising social and health care [valtakunnallinen suunnitelma]
WHO	World Health Organisation

"Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the means for their actual solution."

Rudolf Virchow (Virchow 1941, p. 93)

"Public-health institutions, including international ones, too often ignore the analysis by one of the founders of public health, [Rudolf] Virchow, who noted that "medicine is not only a biological, but also a social intervention and politics is public health in the most profound sense."

Vicente Navarro (Navarro 1997, p. 1480)

1. INTRODUCTION

These two quotes function extremely well as an introduction and rationale to the topic of my master's thesis. I will investigate how the Finnish health policy is defined and organized and also shed light on Finnish health policy formation processes and actors. In this study, health policy is understood as a broader societal construct covering the domains of different ministries, not just Ministry of Social Affairs and Health MSAH (for a more detailed discussion, see Chapter 5). Thus, I will not investigate health care or Finnish healthcare system and this aspect may be good to keep in mind.

I will examine more closely *The Government Resolution on the Health 2015 public health programme* [later: Health 2015] (Ministry of Social Affairs and Health 2001) as a case. Health 2015 has been chosen for this study because it is at the moment the only comprehensive and formal public health programme in force, and it was prepared in 1997-2001 – in the middle of a major turmoil in Finnish public administration. Health 2015 seemed to be an interesting case also for another reason; a mid-term evaluation (Muurinen, Perttilä & Ståhl 2008) showed

that it was not very well known in municipalities and respondents' opinions were quite critical.

In the 1990s, the operational environment changed due to economic recession, state subsidy reform in 1993, globalization, and joining the European Union (Melkas, Lehto, Saarinen & Santalahti 2005). Therefore, investigating this document and the preparatory process has offered me a rewarding window to this era but also given me a new understanding of how things and events may occur in institutional decision-making process. I have also learned how certain situations may look totally different from outside than how the actors in focus experience them.

This journey has been much more fruitful than what I knew to expect. Anu Kantola has investigated political governance in the early 1990s recession in Finland in her doctoral dissertation and writes that there seemed to be things that no one wanted to say in public; she felt that she saw only the tip of the iceberg and she had to dive under the surface of the water to see where it started and how the iceberg was actually constructed (Kantola 2002, 19). That summarises quite well my feelings as well; I thought I was delving into health and health policy but soon I found out that I have to study the Finnish and Nordic welfare policy, the 1990s recession, the European Union, and WHO closer. I ended up discussing the essence of democracy, politics, managerialism, parliamentarism, whether it would be more economical for a state if people died right after they have retired, and what the point is in trying to secure *“more years in life and more life in years”*, as the saying goes.

I also realised that apparently there are all kinds of tension built into health policy, and if I am not careful, I may unwittingly take side. There are several matters that experts and professionals do not necessarily agree on, such as the existence or even conceptual possibility of evidence-based policy making, if health policy and social policy are equal or if the other is subordinate (e.g. Sihto 2011) and if, which one. The term “welfare” seems to be problematic as well; it may include or

exclude health, depending on whom one asks.

The idea for my thesis was born in February 2011, when I attended a two-day working seminar "*Health Forum 2011*" arranged by The Finnish Medical Society Duodecim, the MSAH, the Association of Finnish Local and Regional Authorities, and the National Institute for Health and Welfare (THL). The theme for the seminar was "Choices in Healthcare" and it was targeted for the decision-makers in healthcare both at national and local levels. During the final discussion some participants, which I would call the *crème de la crème* of Finnish health(care) policy, pointed out that in Finland, there is actually not much research done on how health policy and social policy decision making and processes actually happen and how health policy is made. Someone summarised it approximately as "*politicians make decisions somewhere and somehow, and decisions are based on something*". The participants were also wondering what is the influence and role of patient and public health organizations and how health policy programmes and platforms of political parties influence political decision making and the Finnish healthcare system in general. Someone also asked if the platforms are even based on facts in the first place. Also the role of THL as an initiator was discussed.

After these questions were posed, my inner political scientist was awakened and I started to wonder how it is even possible that all these people working on healthcare field or in health policy making are asking these questions. I also started to think that if they really do not have information on those matters, it is even more worrying, keeping in mind that the MSAH administers approximately 23% of the state budget (Valtiovarainministeriö 2012) and as health issues extend also to domains of other ministries, which will be shown later in this paper, the lack of knowledge of health policy actors and processes appeared especially alarming.

The discussion on national health policy is very often understood as discussion on healthcare or medical care policy. However, many scholars (e.g. Navarro 2007; McGinnis, Williams-Russo & Knickman 2002; J.M McGinnis & Foege 1993; Lalonde 1974) have pointed out that healthcare sector and medical care may affect only a fraction of population health but it still takes most of the money com-

pared with what is invested in health promotion, prevention or tackling so called social determinants of health. It has been estimated that in the US even 40 percent of deaths are caused by behaviour patterns, which could be changed by preventive interventions, not to forget social circumstances and environmental exposure (McGinnis et al. 2002). To turn it the other way around, some researchers have estimated that medical care accounts perhaps only for 10% – 20% of the factors that shape health (see e.g. Teutsch et al. 2012; Booske, Athens, Kindig, Park & Remington 2010). On the other hand, it is true as well that for some decades ago health care may not have had that much to offer, for instance the sanitary revolution was more significant in terms of public health, but healthcare and medical care technology, procedures and drugs have improved and their role have also changed. Nolte and McKee (2004) have shown that despite differences between countries and systems, health care does indeed matter and it reduces e.g. infant mortality and deaths among the middle aged and elderly. Also Matti Rimpelä (2010, p. 20-21) has criticised claims that health care would have only a small influence on public health and says that the original thoughts of Thomas McKeown (1976) have been interpreted wrong.

Very soon I noticed that the lack of research is really true: there was not much earlier let alone recent research done on health policy, especially from political science point of view. For instance healthcare systems, leadership, health innovations, health promotion, epidemiology, clinical medicine and social determinants of health have all been covered better than approaches such as “politics of health” or “politics of health policy”. In Finland, research on health policy and politics has had scientifically a “supporting” role (Lehto, Ashorn, Solin & Tervonen-Goncalves 2006). For instance, professor Ilkka Ruostetsaari has presented a review which showed that during the past decades only a fraction of a percent of Finnish political science master’s theses and doctoral dissertations have handled health policy (ibid., Ruostetsaari 2005). In his analysis, Ruostetsaari found some possible explanations for the lack of health policy research. Firstly, political science students very rarely plan their future career to be in social and healthcare sector and therefore the choice of minor subjects may not support

choosing health policy as their thesis topic. Secondly, social and healthcare sectors have also traditionally been dominated by strong health professions, which have not necessarily left space for political scientists. Perhaps political scientists have also not been seen as relevant stakeholders.

However, Ruostetsaari points out that it is not in any way self-evident that political science would not have a lot to offer for health policy research. According to Ruostetsaari, political science is actually an extremely significant policy area taking into consideration that usually social and health policy takes the single largest slice both in municipal and state budgets. Also power, as one of the most central research themes in political science, the constantly changing relationship between state and municipalities or e.g. non-profit organisations are relevant in this context. Understanding power and political processes is essential for understanding politics and societal change, and without this information it is also difficult to try to influence political decision making.

When citizens are asked for their priorities in life, health is usually at the top of the list. Nevertheless, politicians or political parties do not seem to be that interested in comprehensive health policy, and mainly health care and service production are discussed. The era of political health policy programmes seems to be over, at least for now, and one reason may be lack of health policy research and information, and also the absence of passionate health policy advocates.

Recently, the most heated political discussion has been on Act on Care Services for the Elderly [vanhuspalvelulaki] ("Hyvään hoitoon tarvitaan rahaa" 2012). The latest turn was a public disagreement between Minister of Health and Social Services, Maria Guzenina-Richardson (SDP) and the Head of Unit of Ageing and Services in National Institute for Health and Welfare THL, Harriet Finne-Soveri (Ahokas 2012; Raeste & Ahokas 2012; THL 2012a). Also other political parties, trade unions and other interest organisations have been involved in the discussion, which makes it an excellent real-time example in terms of the content of my study. In my opinion, the current political discussion is very welcome, even if I do

not necessarily agree with all the arguments and their reasoning which various actors have presented. Any discussion, however imperfect, is better than no discussion. To give one frame to the recent activity, it is also worth noticing that municipal elections will be held in October 2012.

Therefore, this study tries to raise discussion and show why health is political and why health really matters. In addition to description of *what* has happened, I will present my view on *why* things may have happened (c.f. Buse, Mays & Walt 2005, p. 7; Bernier & Clavier 2011).

Besides increasing knowledge of Finnish health policy, this Master's thesis is important and topical for another reason. The MSAH and the Advisory Board for Public Health will soon publish a mid-term evaluation of Health 2015 (Sosiaali- ja terveystieteiden ministeriön ja Terveystieteiden ja hyvinvoinnin laitoksen asiantuntijatyöryhmä & Kansanterveyden neuvottelukunta 2012) According to my information, the MSAH is at the moment considering if there should be another long-term public health programme after Health 2015. I hope to offer the Ministry and the whole Government new information and thoughts to be discussed.

It is notable, that lack of political science research on health policy and politics is not unique to Finland. Navarro (2008, 354) writes that he is surprised to notice that while there are a growing number of articles that focus on the social and cultural determinants of health, there are very few on the political determinants of health. He continues that this is remarkable because one would have thought that in democratic societies, public health scholars and analysts would study how the various instruments, such as political parties, shape public policies.

The doctrine of New Public Management NPM (e.g. Boston, Martin, Pallot & Walsh 1996; Hood 1991) has had a significant role in the reforms of Finnish public administration in the 1980s and 1990s, and the development has continued in the 2000s, as well (Lähdesmäki 2011, 75). To be able to link my study to a broader context, Finnish health policy and Health 2015 will be analyzed against the

the change of administrative regime, and NPM will function as a kind of lens through which I will eye the process and results.

The State productivity programme, launched by Vanhanen Government in 2003, has been understood as continuation to NPM influenced public health reforms. As my case is a programme document, my original idea was to include the governmental regime of programme management (Kekkonen 2007), which came into force in 2003, and to scrutinise if and how my case is related to the new system. However, I eventually decided to exclude it from my study because it appeared a little bit unattached and it would have added yet another piece to this already quite tricky puzzle. Nevertheless, to understand better administration and managing by programmes I have studied programme management as well. Of recent Finnish studies, Annukka Berg's (2012) and Liisa Heinämäki's (2012) fresh doctoral dissertations address e.g. programme management, governmental processes, and some other relevant institutional questions, and while the former discusses sustainable consumption instead of health policy, Berg's findings are also comparable with my study at institutional and phenomenal levels.

The policy documents that have been investigated consisted of papers and reports produced by the MSAH, the Finnish Government (e.g. Valtioneuvosto 2007) and by sectoral research institutions, such as THL, Kansanterveyslaitos (KTL), Stakes (e.g. Sihto 1997; Muurinen, Perttilä & Ståhl 2008), National Audit Office (e.g. Valtiontalouden tarkastusvirasto 2009; 2010) and World Health Organization (2002). I have mainly focused on policy developments and actions linked to Health 2015 and what has happened since then in this field.

To gather sufficient knowledge on the topic of health policy, I have systematically studied the following English-language journals (2000-2011): *Health Affairs*, *Health Policy*, *Health Policy and Planning*, *Health Promotion International*, *European Journal of Public Health*, *International Journal of Epidemiology*, *International Journal of Health Planning and Management*, *Journal of Epidemiology & Community Health*, *Journal of Health Politics, Policy and Law*, *Journal of Policy Analy-*

sis and Management, Journal of Public Health, Journal of Public Health Policy, Policy and Politics, Policy Studies Journal and Policy. Of Finnish-language journals I have studied *Yhteiskuntapolitiikka* (Societal Policy) and *Sosiaalilääketieteellinen aikakauslehti* (Journal of Social Medicine).

2. AIMS, STRUCTURE, METHODS, DATA, RELIABILITY, AND VALIDITY

“The Constitution designates a significant role to municipalities in securing the citizens welfare. The Government carries the responsibility...or not because the Government says it cannot influence the rules of economics. Also the citizens seem to be perplexed by who is responsible for what, for instance what a Ministry in fact can or cannot do and what municipalities should be capable of doing.”

– Vappu Taipale (Raivio 2008, p. 54) [translation from Finnish by JV]

2.1 The aims and structure of the study

This study is a qualitative case study. The original research idea was to investigate how the *Government Resolution on the Health 2015 public health programme* was developed and which actors participated in the process. However, it is not possible to understand the nature of Health 2015, the actors, process and the final policy document without understanding the wider national and international context. Therefore, health policy and particularly Finnish health policy are addressed from a theoretical perspective, but the aim is also to present new information. The research questions will be explained below.

Institutionalism, policy transfer and corporatism will form the theoretical framework for this study (Chapter 3). New Public Management (NPM) is relevant for understanding the contemporary change in Finnish public administration, especially regarding the relations between state and municipalities, the 1990s recession, emerging of programmes, projects, and finally the change in administrative preparation structure when the Government slowly abolished political committees. These questions will be discussed in Chapter 4.

As I mentioned in the Introduction, health policy is often regarded as healthcare policy, but this study understands health policy as a wider societal concept. To

understand what we talk about when we talk about health policy, we need to understand what is meant by health and policy; the purpose of Chapter 5 is to answer these questions. In this work I understand *public health* and *population health* as synonyms, more discussion on this will be also found in Chapter 5.

Chapter 6 will present an overview of Finnish health policy, its historical background and administrative structures. Actors of Finnish health policy will be presented and discussed in Chapter 7. This knowledge will give sufficient information to proceed to Chapter 8, which is the case study part of this paper.

This leads us to the research questions. The aim of this study is to answer the following questions (Chapter 9):

- (1) What is Finnish health policy?
- (2) Does someone actually coordinate Finnish health policy, and if so, who or which institution(s)?
- (3) Is Health 2015 a public health programme; does it fulfil the criteria for a policy according to indicators drawn from policy analysis?
- (4) Do the Health 2015 preparation process, content and actors reflect the implementation of NPM in Finnish public administration?

The first question may sound trivial but as will be shown later, the answer may not be that simple. There are official guidelines, mantra even, for the content and definitions for Finnish health policy, but this study will discuss whether the reality corresponds to fine words and what conclusions can be drawn.

The second question is closely linked to the first one, and for the answer, same controversy applies. By coordination, this study understands, modified from (Bouckaert, Peters & Verhoest 2010, p. 16)

“a process, strategies and instruments, which governments use to steer and manage organisations or programmes within the public sector”.

In many aspects, in this context coordination resembles “power”, but I preferred coordination because it refers to a process and it is an active term.

The third question may sound semantic but it is not, or at least not completely. Health 2015 will be investigated using a policy analysis model from (Cheung, Mirzaei & Leeder, 2010).

The fourth question is linked to the third one and the aim is to examine Health 2015 in NPM context.

2.2 Methods and data

This study is a qualitative case study. According to Yin (2009, p. 18)

“A case study is an empirical enquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident”.

Hirsjärvi, Remes and Sajavaara (1997, p. 165) summarise the features of qualitative research as follows:

- the nature of research is comprehensive and research material is gathered in real-life situations
- a human being is favoured as an instrument for gathering information
- the analysis is of inductive nature
- qualitative methods in gathering data
- the respondents are selected precisely instead of a random sample
- the research plan takes shape along the research process
- the cases are considered unique and the research data are interpreted in accordance to them

The data of this study consist of the minutes of the Advisory Board for Public Health (1997-2000), Finnish health policy documents, main emphasis being on Health 2015 programme, earlier research and publications. In addition to written data, I have executed supporting interviews with previous and present Finnish civil servants, researchers and health policy professionals.

2.2.1 Semi-structured interviews

Interview as a method is useful when a researcher is exploring a subject, which is still unknown. By applying interviews, the researcher is aiming to transmit the thoughts, perceptions and experiences of the interviewee. The difference between a discussion and an interview lies in the composition: the participants are not equal, and the interviewing situation is to be understood as a systematic, planned form of gathering data. (E.g. Hirsjärvi et al. 1997, p. 200-4; Hirsjärvi & Hurme 2000, p. 41-3.) There is no single definition for a semi-structured interview and some scholars use it as a synonym for a thematic interview or a focused interview. However, in thematic interviews there is not a designated set of questions but it is based on thematic topics that are discussed. The difference between thematic and focused interview is that the thematic interview is close to non-structured interview, but in focused interview the researcher has already investigated the theme, phenomenon, structures and processes, and based on that information he or she has drafted the interview questions. (Hirsjärvi & Hurme 2000, p. 47-48.)

In this study, a semi-structured interview refers to a focused interview which is based on sets of questions that were presented to the interviewees, either in two or three sets, depending on the respondent's background. For the template of interview questions, see Appendix 1. The order of questions varied as sometimes the interviewees answered some questions before they were even presented. The general rule was, however, that all questions were covered: even if some topic appeared implicitly in an earlier response, that question was presented explicit at some point of the interview.

The informants were selected using a combination of an elite and a snowball sampling method¹. Based on policy documents and other literature, I drafted a list of names, which seemed to be relevant for studying Health 2015 and Finnish health policy, and eventually that list appeared to be quite accurate. When the interviewees were contacted for the first time, most of them recommended other experts or civil servants and quite soon the list of names reached the saturation point and it was confirmed. The final number of respondents was 17, and although there were still three more names that appeared in some interviews, I decided to exclude them from the sample. One reason for this decision was the characteristics of a master's thesis: almost twenty informants is already a very comprehensive group. Secondly, these persons would have definitely been interesting to talk to, but I do not see that they would have significantly affected the results and their viewpoints were already covered by other respondents. Therefore, keeping in mind the tight schedule, I was confident with settling for this group of handpicked experts.

The informants were contacted by e-mail in January 2012 and the interviews took place in April 2012 – May 2012. The interviews were executed either at the informant's workplace, a café, a restaurant, or at the informant's home. Fourteen were individual ones, one was a pair interview, and one was a phone interview. The interviewees were given the general research themes in advance, but not the whole set of questions, the only exception being the phone interview to enable a smooth session. This decision was made to allow the respondents to answer as freely as possible and to prevent "censorship" of the content due to "rehearsed answers".

The informants gave their permission to publish their names in a separate list and the list of interviewees can be found as Appendix 2. The interviews were recorded with permission of interviewees and the length of recordings varied between 1 h and 3h 42 min. The average length was 2 h. I transcribed the recordings word for

¹ http://www.fsd.uta.fi/menetelmaopetus/kvali/L6_2_4.html

word, which resulted in 550 pages in line spacing 1, point size 12. For analysis, the transcriptions were classified and summarised. The respondents are divided in three categories: 1) “a civil servant” (CS), 2) “a researcher” (R), and 3) “other” (O). There are several persons with multiple recent or current “hats” but these categories are based on the position in which they are interviewed: either as a participant in the Health 2015 process or their leading role in Finnish health policy. The referring codes for quotes used in this study are randomized to avoid recognition. In other words, the list of interviewees is in alphabetical order but “CS1” is not the first civil servant on that list.

2.2.2 Policy analysis

Policy analysis as a method can be linked with institutionalism and different theories of political decision making (see Chapter 3). The terms “policy analysis”, “policy sciences” and “policy studies” are sometimes used interchangeably (e.g. Hogwood & Gunn 1984, 16), but in this study, “policy analysis” is used. Policy analysis has developed in the US already in the 1930s but the true heyday begun in the 1950s and 1960s. The US political system has influenced the theories and need for policy analysis, and especially most of the early policy analysts were American.

The early fathers of political science with focus in policy processes include Harold Lasswell, Herbert Simon, Charles Lindblom and David Easton (Parsons 1995, p. 21). The decision making theories of Simon and Lindblom are briefly discussed in Chapter 3 of this study.

The holistic idea behind policy analysis is based on rational exploration of public policy and administration, influenced by an approach similar to natural sciences. The character of policy analysis is multi-disciplinary and it can be applied to several policy areas.

Policy analysts have been called e.g. “the physician to the political personality”, “the social engineer” or “the intelligence gatherer” (for references, see Parsons

1995, p. 30). Merelman (1981, p. 496) has even compared policy analysis to psychotherapy as he writes

“(--) learning to be a policy scientist is self-therapy, for it obliterates the social scientist's lust for power. Thus, policy science is therapeutic and pragmatic; the social physician heals himself while learning to heal the polity.”

Policy analysis can be divided in two: “analysis of policy” and “analysis for policy”, and this study mainly belongs to the first category. That includes policy determination (how policy is made, why, when and for whom) and policy content. (Parsons 1995, p. 55.) However, this study may be understood also as “analysis for policy”, especially regarding policy environment and actors.

Parsons (1995, p. 29-30) has summarised the functions and interests of a policy analyst as follows:

- they are concerned with problems and the relationship of public policies to these problems
- they are concerned with the content of public policies
- they are concerned with what the decision makers and policy makers do or do not do. They are interested in the inputs and processes of a policy area
- they are concerned with the consequences of policy in terms of outputs and outcomes

There is a variety of analytical policy analysis frameworks, but for this study, public choice theory, institutionalism and political process are relevant (for more detailed description, see Parsons 1995, p. 34; 39-40).

Due to multidisciplinary approach and several definitions of “policy” (see Chapter 5), policy analysis may be used for e.g. analysing specific issue, programme, multiple programmes, strategic policy decisions and broad policy choices (Carley

1980; Parsons 1995, p. 395-7). Commonly, policy analysis is used for analysing policy change and the content and implementation of a policy or programme. However, in health policy research, policy analysis is still not fully used as a method and as problems and operational environment become more complex, there is a growing need to produce information for policy-makers regarding e.g. how efficient certain policies and interventions have been and if they need adjustment (see Collins 2005; Buse 2008; Gilson, Buse, Murray & Dickinson 2008; Walt et al. 2008).

A key difference in the research of policy processes is the way the process itself is understood: as proceeding in clear, rational stages, in a cycle or perhaps without any rational idea. Of the most renowned names, Simon, Lasswell, Rose, Jenkins and Hogwood & Gunn represent the “stagist approach”. In this study, however, that kind of rational and logical decision-making process is considered to be unrealistic and not reflecting reality. Therefore, policy processes are regarded to be more complex and rather to follow the thoughts of Bachrach & Baratz (e.g. 1963) and Lindblom (e.g. 1979).

The more recent approaches of policy analysis have discussed agenda setting and networks. Mikko Mattila (2000) has used network analysis in his doctoral dissertation and this paper will partly use his typology of Finnish health policy actors added with some new ones. Paul Sabatier’s advocacy coalition theory (e.g. 2007) is very popular, but it is not applicable in my study. However, John Kingdon’s (e.g. 2011) model of policy streams is applicable with his refinement of the idea of “garbage can”. Kingdon’s model has also been tested in Swedish public health policy research (Guldbrandsson & Fossum 2009; Mannheimer, Lehto & Ostlin 2007).

Policy analysis can be criticised for a good reason for oversimplifying the decision-making process and for finding meanings where they do not exist. Policy analysis can also be used to justify some already made decisions and if the analyst has some kind of political or corporate background, analysis can become some-

what “coloured”. This may be especially problematic in systems with strong lobbying culture. To reduce the risk of error, analyst and the client must be aware of these potential pitfalls.

2.2.3 Written data

My primary research material is Health 2015 document as well as the minutes of the Advisory Board for Public Health (1997-2000). Health 2015 was published in May 2001, but unfortunately I was not able to get any minutes from the end of 2000 or the early 2001. Nevertheless, as the Health 2015 process was mostly proceeding in the “black box” (Easton 1965) of the MSAH in 2000 and 2001, the short gap in the minutes in the end of the process have not significantly affected my results. My original plan was to contact the MSAH and familiarise myself with the documents and based on them, decide on the interviewees and draft the questions. However, after contacting the MSAH in January 2012 I found out that all the preparation material has been thrown away or disappeared, so there were no documents left. Usually Ministries diarise the most important documents, but this process had been different and there was no written or electronic material available, partly due to relocation of the MSAH and also transition to a new IT system. At this point in January, I contacted almost all my potential informants and asked if they would have kept any of the material. Finally, one of the contemporary secretaries for the Advisory Board for Public Health, research professor Seppo Koskinen, found a box of minutes and other preparation documents which he kindly loaned for my research. In my understanding, this set of papers may be the only documents left of the Health 2015 process. For analysis, these documents have been investigated and classified to complement interview data.

2.3 Validity and reliability

The validity and reliability refer to evaluation, whether the results are reliable and reproducible, if the methods have been accurate and if the results and research design have been carefully scrutinised for avoiding scientific bias.

I have studied the subject carefully before planning the research design and de-

ciding on the interviewees to ensure that I have a comprehensive understanding of the topic and I am able to find the right informants. Systematic review of the journals and my professional background, almost eight years in the Parliament of Finland, have helped me to understand the dimensions and connections between different events, persons and institutions. My work experience enabled me also to listen to the interviewees with attention and notice possible hidden agendas, which were present in some interviews. However, as I am literally impartial, I was able to treat all participants equally regardless of their political status. The interviews were recorded, which allows subsequent interpretations, and transcriptions were classified and analysed using logic constructs that are consistent with my research questions.

As I mentioned in Section 2.2.1, the interviewees did not receive the questions beforehand, which might have caused a problem if there had been less time. However, as the average length of an interview was two hours, it was possible to return to earlier themes and to present detailed questions to make sure that necessary aspects were covered.

There are no municipal representatives in the sample, which can be seen as a weakness. However, regarding Health 2015, the contemporary representatives from City of Kajaani and the Association of Finnish Local and Regional Authorities could not be reached and the present persons in possession do not have the information. On the other hand, according to the minutes, neither of these municipal representatives appeared in a notable role in the Health 2015 process.

Regarding interviews, there is always some unreliability present, especially when encouraging the interviewees to remember events and processes that happened almost 15 years ago. Also personal relations, experiences and political stance may affect responses. Those respondents who are already retired are probably more willing to share their sincere thoughts than those who still have duties. The error was minimised by expanding the sample for establishing as objective description as possible in qualitative research.

The results regarding Health 2015 date partly back to years 1997-2001, after which the Finnish public administration, processes and actors have changed to some extent. Especially the structures of programme documents, evaluation systems, and measures have improved. However, my observations are still relevant and applicable in present reforms, programme processes and Finnish health policy making in general.

3. THEORETICAL FRAMEWORK AND APPROACHES

Health policy can be understood and investigated in different contexts and frameworks and the same events can offer a researcher many possibilities for approaching the subject. Study of power and institutions are in the core of political science and modern governance largely occurs in and through institutions. Power is typically wielded, and also resources are mobilised through institutions or by those who function in them.

Most of my work deals with institutions, such as the Ministry of Social Affairs and Health (MSAH), the National Institute of Health and Welfare (THL) or Health 2015 which, as a policy document, can also be understood as an institution. Therefore the concept of *institutionalism* or *institutional theory* is the most relevant framework. As to content of Health 2015 and its predecessors as well as the Finnish health policy in general, the idea of *policy transfer* seems to be applicable and it explains quite well the adaptation of certain policies and issues in Finnish health policy. Policy transfer can also be used to understand how Finland has influenced international organisations, especially WHO, to which I will return in Chapter 6. Policy transfer tangents institutional concepts of *organisational learning* and *path dependency* which are both discussed briefly. Although I have not included network analysis in this paper, understanding the nature of Finland as a corporatist state is essential when taking a closer look at the actors in Finnish health policy and in the Health 2015 process. Therefore, I will present some relevant aspects of *corporatism* and *public choice theory*.

3.1 Institutional theory and rational decision making

The Oxford Dictionaries define (2010) *institution* as follows:

1. an organization founded for a religious, educational, professional, or social purpose
2. an established law or practice
3. the action of instituting something

The definition is quite extensive, and Elinor Ostrom (2007, p. 23) has pointed out that scholars have defined “institution” as meaning almost anything, and that a major confusion exists between those who use the term to refer to an organisational entity and those who refer to the rules, norms, and strategies adopted by individuals operating within or across organisations. In this paper institution is indeed understood in both ways, although I comprehend the necessary distinction between these two approaches.

While modern political science and public policy have developed during the decades, institutions have sometimes been forgotten as a stage for policy making and politics. However, if one wants to understand the process of policy formulation, the institutions cannot be forgotten. (Parsons 1995, p. 223.) If processes are sometimes difficult to investigate, also institutions can cause problems. They may be “invisible” because they exist in the minds of the participants and sometimes they can be just shared knowledge, so a researcher must find a way to identify and measure them (Ostrom 2007, p.23-24). The field of comparative public policy is, according to Heidenheimer, Heclo and Adams (1990, 3), the *“study of how, why, and to what effect different governments pursue a particular courses of action or inaction”*.

In short, institutional approach concentrates on the role of state and social institutions and what is their role in both defining and shaping public policy.

It is not pertinent to this work, and therefore not necessary, to go into details of different schools of institutionalism. The main division is done between so called “old institutionalism”, which was more descriptive than explaining, and on the other hand “new institutionalism” (March & Olsen 1984), which was born in the 1980s and combines the formal institutions and human behaviour. There are also different sub-groups of institutionalisms and each social science discipline is said to have its own “new institutionalism” (see e.g. Peters 2005; Lowndes 1996; Weaver & Rockman 1993). There are also different approaches regarding how the nature of institutions is understood and how e.g. the rules are translated into po-

litical impacts or how human behaviour is translated into structures and how these translation processes sustain or eliminate. Institutions can be seen creating elements of order and predictability, they provide bonds that tie citizens together, and they also impact institutional change creating elements of “historical inefficiency” (March & Olsen 2005). By that, they mean (ibid., p. 13) that institutions become in some sense “better” adapted to their environments.

Sometimes it is argued that some degree of rationality in policy making is a prerequisite for a “good policy”. This study will not cover decision making theories as such because decision making processes are scrutinised at a general, institutional level. However, e.g. policy transfer is usually understood in the context of rational decision making and to be able to examine my case more closely from a decision making process perspective, some points are presented here.

Herbert Simon has defined (1972, p. 161) rationality as follows :

“Rationality denotes a style of behavior that is appropriate to the achievement of given goals, within the limits imposed by given conditions and constraints”

As was case with the institutions and Ostrom’s (2011; 2007) standpoint, also Simon distinguishes individual and organizational when he writes about rationality. He introduces a kind of combination model, “bounded rationality”, starting point being in rationality, but the model takes into consideration the uncertainty of variables and that a decision-maker does not necessarily have full information about alternatives.

One can presumably assume that rational decision making theory and rational choice theory implicitly recognize an actor or an institution to have a, at least somewhat, clear understanding of the desired result. However, Abert (1974) commented already for almost 40 years ago that there seems to be almost no agreement among those who are involved in policy making about what they

should do and when. He writes that very often it is not because of lack of talent or resources, but because no one knows or can agree on what they are doing, and if they do agree, they can become blurred at the next "change of watch". Abert's thoughts go well with Bachrach's and Baratz's (1963) note on how there are a variety of complex factors that affect decision making, such as the backgrounds of participants, pressure coming from outside and the values of the decision making body. They also point out that a process, which they call "non-decision making" may be as important as the actual decision making (ibid. p. 632; p. 641-642).

Lindblom (1979; 1959) investigates political decision making from a similar point of view and writes that regarding complex social problems and policies, it is impossible to consider all the information, values, opinions, and preferences. A high degree of administrative coordination occurs as each agency in federal administration adjusts its policies to the concerns of the other agencies. Lindblom (1959) discusses the different approaches of a decision-making theorist and a practitioner and presents a decision-making model which he calls "muddling through". Later (1979), he mentions that also the term *incrementalism* has been used to referring to this model which can be summarised to be "political change by small steps" (ibid., p. 517). The core idea in "muddling through" is, using a tree metaphor, that administrators make decisions by looking "branches" nearby, so they look at policies that differ in relatively small degree from the current policies. Hence, they are not looking at the whole tree or the roots, which simultaneously narrows the scope of investigation so. policy options available. All policy analysts have not agreed with Lindblom, and incrementalism has been said to be slow, inefficient and often even preventing political change. Lindblom answers (ibid., p. 520-521) his frustrated critics by saying that they are partly barking up a wrong tree and e.g. some problems inherent to the US politics are not caused by incrementalism as a model. He defends his ideas by saying that "incremental politics ordinarily offers the best chance of introducing into the political system those changes and those change-producing intermediate changes that a discontented citizen might desire."

Policy analysis as a method and policy making frameworks are discussed more closely in Section 2.2.2.

3.2 Policy transfer, organisational learning, and path dependency

Policy transfer, lesson drawing, policy diffusion, policy borrowing, policy convergence and policy shopping are theories and expressions that appear in the study of international relations, political science, public policy, sociology and also in other similar fields (e.g. Marsh & Sharman 2009; Stone 2001; Freeman 1999; Cox 1993). These terms are sometimes used interchangeably as well although there usually are slight differences in what is included and meant by them.

The whole concept of *lesson drawing* was drafted by Richard Rose (1991). He was interested in the prerequisites and the scope of which a programme, which is effective in one place, could transfer to another.

He argued (ibid., p. 3) that

“Every country has problems, and each think that its problems are unique (--) However, problems that are unique to one country (--) are abnormal (--) confronted with a common problem, policy makers in cities, regional governments and nations can learn from how their counterparts elsewhere responded.”

The idea of lesson drawing has been developed by David Dolowitz and David Marsh (1996; 2000) and they launched the term *policy transfer*. Their, probably the most quoted, definition is as follows (p. 344):

“*Policy transfer, emulation and lesson drawing all refer to a process in which knowledge about policies, administrative arrangements, institutions etc., in one time and/or place is used in the development of policies, administrative arrangements and institutions in another time and/or place.*”

In distinction to Rose, Dolowitz and Marsh make a difference between “voluntary policy transfer” and “coercive transfer” and consider Rose’s lesson drawing to go into the category of voluntary policy transfer. Dolowitz and Marsh refer to some earlier research and name six main categories of actors: elected officials, political parties, bureaucrats/civil servants, pressure groups, policy entrepreneurs/experts and supra-national institutions. The European Community is taken as an example (*ibid.* p. 346), but policy transfer has been said to concentrate more on other international organizations than European Union. In the recent years the European Union has eventually been in the focus of some scholars (e.g. Bulmer, Dolowitz, Humphreys & Padgett 2007; Bulmer & Padgett 2005), but more research is needed as the EU is a powerful platform for policy transfer. Bulmer and Padgett showed (2005) that transfer processes and outcomes are institution-dependent and the relationship of asymmetrical power will tend to generate coercive forms of transfer, which would support Dolowitz’s and Marsh’s idea of different kinds of transfer. Stone (2004) mentions even a third option, “soft” forms of transfer, by which she refers to transfer of norms and knowledge as opposed to “hard” transfer of e.g. policy tools and structures.

Policy transfer research was very active in the late 1990s and mid-2000s but since it has been said to have reached a more mature stage (Benson & Jordan 2011). Originally policy transfer research was more state-centric, but recently other actors and venues have been involved and policy transfer has been used to study e.g. public education, crime, creative industries and social and welfare policy (see *ibid.*, p. 347).

Policy diffusion literature has been seen to prefer structure while the policy transfer literature has been more interested in agency (Marsh & Sharman 2009). However, Stone (2001) points out that some scholars working on policy diffusion have adopted a more processual perspective, bringing human behaviour and processes beyond structures. Therefore, that kind of emphasis can theoretically be linked with new institutionalism as well (see Chapter 3.1).

Close to this approach, emphasising agency and behaviour, is also a theory of *organizational learning* (e.g. J. March 1991; Levitt & March 1988). It deals e.g. with learning from the experiences of others, organisational memory, how organisations retrieve the lessons of history despite the turnover of the passage of time and personnel, and how organizations cope in constantly changing environment.

As for organizational learning, it can be associated with the theory of *path dependency* (e.g. Sydow, Schreyögg & Koch 2009; Peters, Pierre & King 2005; Pierson, 2000). One, quite broad but applicable, definition of path dependency is from William Sewell. He writes (1996, p. 262-263) about temporality of occurrences and that events are path dependent:

"That is that what has happened at an earlier point in time will affect the possible outcomes of a sequence of events occurring at a later point in time."

Although the idea of policy transfer has spread widely, it has been well accepted and it transfers easily across different disciplines, there has also been some discord. Despite his critical approach, Mark Evans (2009) has ultimately a positive stand on policy transfer and its possibilities. James and Lodge (2003) have meritoriously pointed out some weaknesses in Dolowitz's and Marsh's thinking albeit they partly seem to miss the point. I agree upon their criticism towards the difficulty of defining policy success and failure without any standardized indicators. I also agree with them on the need for measures if and when the claims for the increase of policy transfer are to be verified; it may very well be the case or perhaps this phenomenon is just better recognised. However, I do not quite understand their need to challenge policy transfer advocates by complaining how

"'lesson drawing' is very similar to conventional accounts of 'rational' policy making and 'policy transfer' is very difficult to define distinctly from many other forms of policy making" (ibid., p. 179).

I also do not see their point when they suggest (ibid., p. 190) that

“researchers may be better off using alternative theories focusing more directly on the effects of learning processes or styles of policy making on policy outcomes.”

It is true that the underlying idea in policy transfer is rational decision making and, taking into account certain variables, finding out which solution would suit the actor the best. However, I do not see policy transfer as a concept in anyway opposing or optional to e.g. studying learning processes or policy making. On the contrary, I see the idea complementary and rather resembling a Russian matryoshka doll. Or as Benson and Jordan (2011, p. 374) put it: “(--) a concept like policy transfer has an innate capacity to combine with many different toolkits.”

James and Lodge also connect lesson drawing and policy transfer with so called evidence-based policy making. They write (ibid., p. 187) that

“such initiatives present the risk of being little more than exhortations that policy makers should take all relevant information from their own experience and the experience of others into account in reaching a policy decision.”

It is hard to see the greatest challenge or the primary problem being in whether the policy makers have all the relevant information or not, and I have not understood policy transfer literature suggesting that either. The argument deals rather with if the nature and essence of policymaking is based purely on facts to start with or if there are other factors involved. I will return to this later in Chapter 5.4.

3.3 Corporatism and public choice theory

Although the roots of corporations and corporatism are often understood in the context of professions and industry, trade unions and employers' organizations (e.g. Molina & Rhodes 2002), in this paper *corporatism* refers more generally to a

system in which organised interest groups have significant role and position in the society and policy making. In Finland, as well as in other Nordic countries, the role of organised labour movement is often emphasised (M. Mattila, 1994). Trade unions are a relevant actor in my study as well, and non-profit organizations, such as public health and patient organisations, are considered to act in the same way than the more “traditional” corporatist agents.

The traditional roles and duties of trade unions have changed in many countries along the recent changes in work life due to globalisation and technological advances. Many organizations may therefore nowadays have a wider societal agenda and they try to influence also other policy areas than just those directly associated with their own domain.

Pluralism and corporatism are contiguous concepts in many ways, and in the framework of my study, the classic definitions of Philippe C Schmitter (1974) can indeed be understood as different sides of the same coin.

*“**Corporatism** can be defined as a system of interest representation in which the constituent units are organized into a limited number of singular, compulsory, noncompetitive, hierarchically ordered and functionally differentiated categories, recognized or licensed (if not created) by the state and granted a deliberate representational monopoly within their respective categories in exchange for observing certain controls on their selection of leaders and articulation of demands and supports.”(ibid., p. 93-94.)*

*“**Pluralism** can be defined as a system of interest representation in which the constituent units are organized into an unspecified number of multiple, voluntary, competitive, nonhierarchically ordered and self-determined (as to type or scope of interest) categories which are not specially licensed, recognized, subsidized, created or otherwise controlled in leadership selection or interest articulation by the state and which do not exercise a monopoly of representational activity within their respective categories.”(ibid., p. 96)*

There have been attempts to find illogicalities and deficiencies in Schmitter's constructions (Cohen & Pavoncello 1987) but it is worth noticing that Schmitter himself (1974, p. 94) recognized that his definition of corporatism does not correspond to the earlier ones. He also mentioned that it ignores a number of institutional and behavioral dimensions that some other corporatist theorists tended to stress. However, regarding this study, both definitions are appropriate. For instance, patient organisations can be understood existing under a pluralistic umbrella but as soon as they are recognised by the state, taken into the system and seen as representatives for a similar category of organizations, they can be discussed in corporatist context.

The role of interest groups participating in decision making has been defended with an argument that they bring relevant and grass roots level information to the decision-making process. On the other hand, it has been argued that the presence of interest organisations do not necessarily secure diversity, as usually only the strongest organisations are able to influence the public administrators. (Mattila, 1994.)

Olavi Borg (1990, p. 322) sees that one typical feature in corporatist development has been that it has been considered, or at least feared, to weaken the role of parliaments and bypass the traditional political-parliamentary machinery. Since the 1970s the Finnish labour market organisations have grown, both in members and in budgets, and their operations have become more professional. Pluralism has also been seen to be weak: the important issues may be "invisible" and only issues of secondary importance has been seen to be brought on agenda subjected to pluralistic decision making (Lindblom 1979, p. 525).

Finnish politics has typically endeavoured for consensus (e.g. Airaksinen 2009, p. 100, 189; Pollitt 1999, p. 47), and corporatism has also been linked with consensus-seeking societies (Crepaz & Lijphart 1995; Lijphart & Crepaz 1991).

Immergut (1992) writes about the logic of health policy making in France, Switzerland, and Sweden and discusses e.g. interest group representation. She lists different explanations for the outcomes of health policy, one leading one being

the theory of professional dominance, especially involving doctors as the sole experts qualified to judge the effects of public health programs (also Mattila 1994, 2000). Immergut presents other possible components as well, such as the role of state, especially the role of civil servants, policy legacies, national interest and state administrative capacities. One of her conclusions (1992, p. 82-83) is however that the medical profession has had less impact than is generally believed and if there has been an impact it has been because of different political systems. Regarding Sweden, which is often regarded similar to Finland, she mentions decision making in the executive arena through a consensual process. I will get back to the role of Finnish medical doctors and the Finnish Medical Association (FMA) in Chapter 7.

When addressing corporatist or other interest organisations, very often public administration appear neutral and independent of all influences. However, Buse et al. (2005, p. 27) discuss the differences between pluralists and public choice theorists. They write that public choice theorists claim that actually, a state is not a neutral actor but an interest group which wields power over the policy process. The state represents interests of those who run it, namely elected public officials and civil servants.

Hillman (2003, p. 416-418) analyses the essence of the public interest and writes that if the personal objectives of political decision makers differ from the public policies sought by voters, there is a principal-agent problem present. Public interest may be difficult to define because it depends on who one asks. Also, objectives sought by special interests are often contrary to the public interest. According to Hillman, politicians are mainly interested in winning in elections because otherwise they become "unemployed politicians". To be able to win, politicians need all kind of support, especially financial, to cover campaign costs. In fact, Hillman writes (*ibid.*, p. 442) that politicians may not see accepting money from special interests as corrupt behaviour, but rather a necessity of success in political life.

Although Hillman's thinking is apparently affected quite strongly by the US political system and financial support may not be in such a crucial role in Finland, re-

garding health policy this is however a valid point. There are strong industrial interests and many choices and decisions may be based on “public interest”, but whatever is public interest in terms of health or e.g. economic welfare is not always obvious, or at least not very simple.

The degree of political has varied among Finnish civil servants, as will be shown later, but the state may not always be totally neutral in Finland, either. Civil servants working in an institution, such as a Ministry, may hide behind the “veil of neutrality” and their actions may seem to serve public interest. However, without transparency and clear idea of what is public interest or whose interest the “public interest” is, it may be difficult to estimate e.g. the justification of certain administrative and political acts. For politicians, this consideration should be more self-evident, but recognising implicit influences may also be difficult.

References for public choice theory are also found in Chapter 4.1 (Lähdesmäki 2003).

4. PUBLIC ADMINISTRATION AND NEW PUBLIC MANAGEMENT

Since the 1980s, New Public Management (NPM) has probably been the most discussed and criticised concept of administrative reform; some (Pollitt & Bouchaert 2011, p. 14-15) even say that it has enjoyed almost a too powerful explanatory role. Scholars have slightly differing views on NPM, and in this chapter, I will present both positive, neutral and critical views. The problems, but also strengths of NPM largely depend on the policy sector. Health policy is one of those which is very challenging, and the questions or answers are not always easy. On the other hand, health and social sectors use a lot of resources and are quite expensive, so despite criticism, it may be that NPM spirited management innovations and administrative reforms would also have something positive to offer. Although NPM is often misunderstood of being something very specifically defined, it is not one coherent system but rather a combination of interconnected reform policies and ideas, which form an administrative political doctrine (Temmes 1998, p. 441). One way to describe NPM could be to call it a toolbox for organisational reforms.

As the scientific background for this study is political science, not administrative science, and the research topic is not NPM either, this chapter will definitely not aim at giving an in-depth description of the history and different interpretations of NPM. Nevertheless, I have to do a quick “act of infidelity”, as knowing the basics of Finnish public administration and especially becoming aware of the changes that happened in the 1980s and 1990s are crucial for assessing Finnish health policy and my case. This chapter begins with a short summary of what NPM is and it will proceed to the Finnish viewpoint. I will end this chapter by presenting some future perspectives to the theme.

The political processes and systems cannot be understood without analyzing the organization of public administration and management. The classic questions of political science, modified from the words of Union Leader Sidney Hillman (Time 1966), namely “*who gets what, how, when and why*” cannot generally be answered without investigating and analysing also public administration.

As I was already suggesting in the previous chapter, civil servants and people working in public administration may rather want to state that they only work with non-political administrative issues, and it may be a delicate issue to a civil servant to admit that he/she makes political prioritising. There may consequently be a strong need to represent administrative actions as non-political and measures taken only based on e.g. matter-of-fact knowledge, legislation or established practice. One of the most important results in research on public administration is the observation that the boundary between political and administrative is not always clear and they cannot be examined separately. Therefore, for a political science analysis of public administration the key questions concern power, influence and legitimacy of politics. If currently most political value choices occur through decisions made in public administration and not in democratically chosen assemblies (e.g. parliament, municipal council), it would be fatal to leave out public administration from the analysis. In practice, investigating e.g. power relations in prioritising of health care, it would be meaningless only to analyse government propositions if the actual decision makers were found in healthcare bureaucracy or among doctors. Constitutional law may determine who has the right to make a decision, but it cannot be taken as an empirical fact on who has the real power. The organisation of administration can also be a crucial factor behind failure of action plans or policy programmes of different fields. Failure can naturally happen if the results are not what the politicians wished for, but failure can happen as well if the administrative machinery was e.g. poorly organized, it had too few resources, if staff was unqualified or unmotivated or if the programme was not enjoying legitimacy among the target groups. (Rothstein 1999, p. 7-14.)

4.1 NPM in a nutshell

The term itself, *New Public Management*, implicitly explains the main idea: shifting from administration to management.

Christopher Hood (1991, p. 3-4) summarises NPM as a loose term which has been useful to describe a set of broadly similar administrative doctrines. NPM can be understood to be born alongside the public administration and bureaucratic

reform which penetrated the OECD countries starting in the late 1970s but continuing and strengthening in the 1980s and 1990s (ibid.; Julkunen 2006, p. 77-79). NPM has also been described as a management philosophy which is a combination of doctrines of how to promote efficiency through professional managers (Lähdesmäki 2003, p. 11).

When considering the origins of NPM, there are slight differences in emphasis. NPM has been called e.g. as a marriage of the *new institutional economics* and *managerialism* (Hood 1991, p. 5) or it has been interpreted as a combination of *public choice theory* and *managerialism* (Lähdesmäki 2003, p. 43-53). NPM can be said to have developed as an answer to the ever growing public sector in many Western states. Especially during recession, there was a need for something that could change the balance, and NPM as a counterbalance to expensive and inefficient public sector was seen to improve efficiency.

Behind the need and demands for administrative reforms has been a growing dissatisfaction towards the state and public sector. Especially the basis for budget and financing has been under criticism, and trying to increase productivity and efficiency was the only way out, as the budgets had already reached their limits. Also citizens begun to demand higher quality from public services and "value for money". (Lähdesmäki 2003, p. 9, 61)

Despite different interpretations and modifications, there are some common features that have been understood as the essence of NPM. They are not necessary present at the same time, but have been found in countries which have adopted some kind of NPM regime.

Hood (1991, p.5) has summarised the features as follows (modified from a table):

1. "hands-on professional management" in the public sector
2. explicit standards and measures of performance
(i.e. definition of goals and measures of targets, indicators of clear statement of goals; performance success, preferably expressed in quantitative terms)

3. greater emphasis on output control
(i.e. e.g. resource allocation and rewards linked to measured performance)
4. disaggregation of units in the public sector
(i.e. e.g. break up of formerly “monolithic” units)
5. shift to greater competition in public sector
(i.e. move to term contracts and public tendering procedures)
6. stress on private-sector styles of management practice
(i.e. move away from military-style “public service ethic”, greater flexibility in hiring and rewards; greater use of PR techniques”)
7. stress on greater discipline and parsimony in resource use
(i.e. e.g. cutting direct costs raising labour discipline and resisting union demands)

Pollit (1993) has a quite similar emphasis, although in his language the term “managerisation”, and managerialism in general, is even more visible. He lists among the main elements e.g. marketising and privatisation of public services, managerisation of public personnel policy through decentralisation, and transition to personal responsibility for results.

Lähdesmäki (2003) has made her own classification and outlined the influences both from public choice theory and managerialism to NPM as follows (modified and translated from a table p. 52):

Public choice theory

- better government/governance [hallinto] is always smaller in size
- the understanding of a civil servant can be summarised in an idea of a bureaucrat wasting taxpayer's money
- demands for tighter political steering and control in public administration [to enable politicians to control civil servants and indirectly represent “voters’ interests”]

- citizens are seen as consumers making choices

Managerialism

- generalisation of management
- idolisation of leadership
- results orientation and cost-efficiency
- rewarding staff based on their performance

Although there has not been necessarily a clear understanding of what NPM really is, it has caused strong reactions both in favor of NPM and against. NPM has been considered to be the only possible solution for correcting the failures in the existing administrative system, but on the other hand, it has been seen to destruct all the work that is done to develop a functioning and extraordinary public service (Hood 1991, p. 4).

NPM has been promoted as a neutral and flexible framework, which can be adjusted and applied in various policy contexts and in different political systems. The critics say, however, that NPM has destroyed the existing system but it has neither been able to bring anything new to replace it nor been able to produce the same service at lower costs, which was the aim. (Hood 1991, p. 8-9.)

4.2 Finnish public administration and NPM

Trying to understand when NPM influences gained a foothold in Finland is not an easy task. Very often the 1990s recession has been seen as a starting point for the whirlwind in public sector, but public administration scholars remind us that in fact the administration received critic of being old-fashioned and too bureaucratic and NPM-ish reforms were actually under preparation already in the 1980s, long before recession (e.g. Koivumäki 2005; Pollitt 1999, p. 45-7; Temmes 1998, p. 447-8, 2007).

There has been variation among OECD countries and in different systems in how NPM was adopted (Hood 1995). Finland has been an active member of many

international organisations and therefore it has had access to experiences of several contemporary management concepts. However, according to Pollitt and Bouckaert (2004, p. 239) Finland has not just applied some trending system but instead carefully selected ideas that would suit, adjusted, to the Finnish needs. Also regarding public administration evaluation, the Finnish approach has been described as pragmatic (e.g. Holkeri & Summa 1997).

Distinctive to Finland, administrative change and reform were mainly commenced and advanced by leading senior civil servants and some high-level politicians (Lähdesmäki 2011, p. 75; Pollitt & Bouckaert 2004, p. 241; Temmes 1998, p. 443). As a consequence, administrative and system changes have been considered to be of technical nature and there has not been much public political or ideological debate but instead the reform has been consensual. In the past, senior civil servants were mainly lawyers, which may also have provoked the more bureaucratic approach. (Lähdesmäki 2011, p. 75; Pollitt 1999, p. 47; Pollitt & Bouckaert 2004, p. 241.) Professor Leena Eräsaari, who has been one of the most visible NPM critics in Finland (e.g. 2005; 2006; 2009), has used terms, such as “violence” and “state terror” to describe her interpretation of how NPM was implemented in Finland.

Kirsi Lähdesmäki (2003) has investigated in her doctoral dissertation the role of NPM in Finnish public sector reform from the end of 1980s to the early 2000s, and it is one of the most quoted Finnish-language studies on the subject. According to Lähdesmäki, the most significant reforms were results-based management, commercial enterprises and authority allocation at a lower administrative level. Especially the equalisation payment reform in 1993, which meant transferring authority from the state to municipalities and increasing local responsibilities, was mentioned being the most significant financial decision (ibid., p. 214-218).

Results-based management and equalisation payment reform aimed at decentralisation of administration and making it more flexible. The aim was also to improve services and improve economic efficiency. However, despite the extended muni-

cipal self-government, the reform was not successful in the sense that the strategic competence of state over municipalities increased. (Temmes & Kiviniemi 1997.)

Regarding healthcare sector and NPM, e.g. Hakulinen, Rissanen and Lammintakanen (2011) present in a very compact form the development of NPM implementation in Finland from the health sector perspective. Similarly, Jussi Jylhäsaari (2009) has investigated the change in the management of municipal primary health care organizations and he comments that health and social sector organisations have been adapting to different realities. To secure the services, most municipalities have made NPM choices mainly out of practical reasons, in other words NPM has not been necessarily something the municipalities would have wanted to implement but merely a pragmatic option. (ibid., p. 175-177.)

A recent article on challenges in Finnish health care, especially mental health care, and NPM is an interesting dialog between two distinguished scholars, Pertti Härmäläinen and Markku Temmes (Härmäläinen & Temmes, 2012). Härmäläinen and Temmes articulate clearly their viewpoints, and besides the features of Finnish NPM, also the history of Finnish health care system and the role of professions are distinct. I will return to them in Chapters 6 and 7 (see also Chapter 3.3).

4.2.1 The 1990s recession and NPM

The most visible change in Finland has been said to have happened in 1987 when the Holkeri Government started its term and guidelines for public administration reform started to be documented in Government programmes. However, Finnish political parties have not been active in planning the development of public sector administration, at least they have not written much about them in their platforms. (Lähdesmäki 2003, p. 118-123.)

The 1990s recession was a real turning point for Finnish economy and politics. Due to the economic recession in 1990-1993, the expenditure of the public sector grew to almost 60 percent of the GNP (Tiihonen 1999, p. 3). Many societal decisions had been made resting on continuous economic growth, but suddenly the country was met with a plateau in productivity and right after it was radically even declining. Unemployment rates were abruptly the highest among in-

dustrialised countries, the share of unemployment benefits increased at once, public sector expenses grew, overall tax revenues decreased, and Finland had to go into debt to be able to survive. The terrible economic situation was also followed by raise in taxes and eventually the Government had to start deciding on saving plans. Trying to decelerate and stop the increase in public expenditure is very difficult, because many benefits and other expenses are statute-bound and there are also other societal factors, which the government cannot directly influence. In the beginning of the 1990s, the Government was forced to use a "cheese slicer" to cut expenses. The parliament passed dozens of laws which aim was to save in every budget section. (Kiander & Vartia 1998.)

In 1992, the Budget Chief (currently the State Secretary with the Ministry of Finance) Raimo Sailas presented to the Economic Council of Finland probably the most famous document of that time: his proposition for balancing the state budget, so called "Sailas's List" or "Sailas's Paper" (Sailas 1992). Sailas stated that Finland will have to re-estimate the functions and tasks of the public sector, and this will lead to reduction of the responsibilities of the public sector as well as cutting down some social subsidies and less important services. Adopting and increasing service fees, pruning the public administration and renewing the administrative control system were included in his proposition (ibid., p.7). This process is in a way going on still today, at least the aftermath, and e.g. J.P. Roos, professor in social policy in the University of Helsinki, has criticised (Roos 2008, p. 74-76) that although this document is historically important, it is almost impossible to find online. Roos states that the proposal was after all just a personal opinion of one civil servant, presented self-imposedly. According to the contemporary public opinion, Roos is not alone in his criticism: Sailas's "statement" was one of the few coming from civil servants and in Finland public discussion has been considered to be the domain of politicians, not officials (Tiihonen 1999, p. 7). Be it as it may, Sailas's proposal can be perceived as a visible manifestation of implementation of New Public Management (NPM) in Finland.

Former Chief Director and Head of Department with the MSAH Kimmo Leppo has reflected this era (Leppo 2010a) from the viewpoint of Finnish health policy,

healthcare and the MSAH. The erstwhile Minister of Finance, Jari Viinanen's famous words were "there are no alternatives", but Leppo comments that there are always alternatives and it is either intelligent dishonesty or pure ignorance to say otherwise (ibid., p. 31). The sitting President of Finland, Sauli Niinistö, was the successor of Viinanen in Lipponen I Government (1995-1999). Leppo also comments Niinistö's statement "the era of distributive politics is over" by saying that in his opinion, this sounds weird. Leppo remarks (ibid., p. 31) that politics does not even exist without sharing the societal resources and allocating them the way political decision makers prefer and thus, he interpreted this sentence to mean that in fact the *direction* of distributive politics was changed [italic added by JV].

4.2.2 State vs. municipalities

The Finnish public sector is not a one entity but there are several subsystems. Especially the relations between state and self-governing municipalities have always been full of tension. From municipalities' viewpoint state is constantly transferring more service and financial responsibilities to them, whereas the state considers municipalities to be inefficient and "sluggish".

Before the equalisation payment reform, which came into force in 1993 as was mentioned earlier, the existing division of work can be summarised as follows: municipalities were responsible for organising public services and state financed them and at the same time supervised the operations of municipalities through national boards. The aim was to offer and secure equal public services in the whole country and the state was also able to use different compensation methods to make sure that municipalities were capable of managing. (Julkunen 2006, p. 261-264; Yliaska 2010, p. 363, p. 370-1). Prior to 1993, the municipalities were obliged to plan and report on their activities, but along with the reform, the state lost its strong normative steering mechanism. This has especially influenced the objective of minimising the disparities in health between different population groups, and the guidelines and actions are largely defined at the municipal level. (Koskinen, Sihto, Keskimäki & Lahelma, 2002; Melkas, Lehto, Saarinen & Santalahti, 2006.)

This kind of management system was called *normative guidance* and in health policy it meant that state virtually decided over whether someone could be hired to the local clinic in a municipality. State could also use [financial] sanctions if necessary. The 1993 reform totally changed the system and the normative state regulation was demolished. In the new regime municipalities received subsidies based on their population and municipal structure, which meant in many cases, combined with the mandatory saving due to recession, a significant cut in municipal budgets. (Julkunen 2006, p. 262-3.) The era after 1993 is called time of *information management*.

Based on his research, Yliaska (2010, p. 371) has interpreted this reform in fact to have strengthened the authority of state. He writes that this increment has been the aim already since the 1980s. Yliaska (ibid., p. 373-4) has addressed the changes in municipal-state relations in two contexts.

First, the international criticism towards "institutionalised" state, which resonated well with intrastate political battle between Social Democratic Party (SDP) and the Centre Party; the growing welfare state had led to the growth of central administration. Decentralisation gave more power to the Centre Party, their support being the greatest in small and rural municipalities, and reducing power of national boards enabled overriding civil servants who had supported the structures of Finnish welfare state. On the other hand SDP wanted to get rid of its "bureaucracy party" image as well.

Second, Yliaska scrutinises the reforms in the context of recession. In his opinion, decentralisation meant strengthening the authority of ministries. The recession was a good reason to justify the growing state intervention and managerialism and results-orientation was an excellent tool. Yliaska writes (2010, p. 373-4) that the state operated control over public resources, but at the same time it was possible to say that the "operational" authority has been transferred to the municipalities. The state was also the promoter and developer of the Finnish "innovation system". Yliaska comments (ibid., p. 373-4) that the society transferred from welfare policy to industrial policy; previously public services were handed over to private sector,

and public resources were transferred from municipal services to research and development, as well as venture funding.

One major administrative reform was the abolition of provinces in 2009, and since 2010, the tasks of previous provincial governments have been divided between six Regional State Administrative Agencies and fifteen Centres for Economic Development, Transport and the Environment. The Regional State Administrative Agencies' tasks consist of those of the former state provincial offices, occupational health and safety districts, environmental permit agencies and regional environmental centres, e.g. access to basic public services, environmental protection, public safety and a safe and healthy living and working environment in the regions. (Aluehallintovirasto, 2011.)

4.3 Some relevant changes regarding NPM in Finland

The Finnish administrative system has been historically influenced by Sweden. Until the 1990s, there was a certain kind of dual central government, *National Boards* and Ministries. This two level central government system has favoured the influence of strong civil servant expertise and development of professions. In the administrative reform of the 1990s, national boards were shut down and the position and authority of ministries were strengthened. (Temmes 2004.) Regarding health and healthcare policy, the most significant national board was the National Board of Health [lääkintöhallitus].

Also the status and role of *politically appointed committees* had Swedish roots. Committees were a significant actor in preparation of reforms and jurisdiction but, again, since the 1990s they have been replaced by intraministerial professional working groups and expert consultants [selvitysmies] as well as regular legislative preparation process. This change has occurred because there has been a need for managerialistic efficiency but ministries have also been able to keep projects in their own hands for a longer time before presenting them to the Government. (Temmes 2004.)

One typical feature for information management in Finland has been the major appearance of *plans, programmes* and *projects*. Julkunen writes (2006, p. 264-6) that a new governance system must be able to renew and revise the previous welfare systems but executing even minor reforms seems to require much administrative and political work, discussion and compromises. She feels that fixing old systems is much harder than creating something totally new. Instead of making national policy, there are several local development projects, especially in social and health sector. Wide societal reforms are easier to promote if they have been tried and tested as temporary, regional experiments. According to Julkunen (ibid., p. 267) social and health sectors are quite ambivalent regarding projects: they offer something new and also employ a large number of people. On the other hand, projects are called project factories, circus, jungle or business, and many professionals feel tired and see that they do not have time for their actual job because of constant organisational change and development projects. The most significant problem seems to be that projects do not lead anywhere. Even if a project is a success, it is difficult to have permanent results and make a lasting change.

Eskola, Jyrkämä and Saarela (2012) have taken this worry seriously. They evaluate one recently finished welfare and mental health project, and in their report they offer several recommendations to the financing party, Finland's Slot Machine Association (RAY). RAY promotes Finnish health and welfare and finances yearly over 800 organisations by almost 400 million euros (RAY 2012). One of the recommendations is to extend the funding of the project by one year, which should be used only for ensuring that the results are fully benefited from and the knowledge and experiences can be implemented in the municipality hosting the project. This would also enable sharing the knowledge as "best practices" into similar work communities. (Eskola et al. 2012, p. 289.)

One aspect of NPM, which is relevant to this study, is the question of *management and leadership*. Temmes, Kiviniemi and Peltonen (2001) have not given very flattering image of Finnish administrative management and leadership. They write (ibid., p. 19-21) that although there has always been some management, from a historical perspective the administrative system, rules, structures and status have

been considered more important than management. In spite of this, there have actually been several management projects, training and publications already in the 1970s and the 1980s at government but also local level. The earlier management style can be described goal-oriented managing but NPM changed the balance towards results-oriented managing. In the 1970s, the rhetoric was "human resources administration" whereas in the 1990s the administration has been replaced by management. In public administration, leadership is still considered problematic.

4.4 Future considerations

As I have mentioned earlier, there has not been a single reform model but many variations and the focus of NPM has changed along the years. Christensen and Laegreid (e.g. 2009) discuss NPM and post-NPM, which has been described as "as a return to the cultural norms and values of the traditional Weberian and centralised system" (ibid., p. 17; also Pollitt & Bouckaert 2011; Peters 2010).

In many countries NPM suffers crisis, and Dunleavy et al (2005) have even declared NPM dead. As a replacement they offer a system called digital-era governance.

What will the future of Finland look like in terms of administration?

Risto Heiskala and Anu Kantola have been quite critical and seen (2010) that the administrative change e.g. implementation the doctrines of NPM has led to a situation where Finland is not necessarily a Nordic welfare state anymore but a "coaching state", as they call it. They mention (ibid., p. 136-137) that "non-political", "rational" actors, such as administration innovators, professors, consultants and business gurus have been given an important role in steering the state, in the same time politics has been defined as bad, harmful, even dirty.

In addition, a distinguished scholar Markku Temmes (2007; 2009) has drafted his thoughts on factors that are relevant in the near future. Change is evident, it always is, and globalisation and European cooperation will affect also Finnish public administration. There will be a growing need for knowledge on policy analy-

sis, strategy work and testing different future scenarios. Ministries have already become real expert organisations, and variety of professionals and academics will be needed to assist in finding answers to increasing and more complex societal challenges. Temmes also estimates that evaluation of systems and policies will play a more significant role in the future, and he sees that the discussion on the status of Finnish welfare state and constantly strengthening interest conflicts will be on the agenda.

Both political science and administrative studies have noticed the changing balance in civil servant - politician relations in different administrative and governmental periods (e.g. Juntunen 2010, p. 45-54; Ruostetsaari 2003, p. 84-103; Nousiainen 1992, p. 107-115; Tiili 2008). Temmes (2009) points out that lately, and at the same time when a majority of long-term civil servants will retire or they have already retired, there has been a growing number of politically appointed staff, both in the Cabinet and in Ministries in general. According to him, the political steering culture has indeed changed; the Prime Minister has become weaker whereas individual Ministers and Ministries have strengthened their position. The number of political advisers has grown as well.

With regard to human resources and partly adding to Temmes's observations, Lähdesmäki (Lähdesmäki 2011, p. 84) has seen NPM of the 2010s to be about managing people, not results. She has also speculated that combining ethics and efficiency and different cooperative models in service production will characteristic to the "second wave" of NPM.

The second wave, or at least some kind of re-run, may have begun already in 2003 when Vanhanen Government launched a state productivity programme [Tuottavuuden toimenpideohjelma VM121:00/2003]. The aim was to add productivity and efficiency in public administration and services by structural and functional reforms. It has not been as successful as the Government was hoping (e.g. Soukainen & Tiili, 2010) but the evaluation is still under process.

All in all, the Finnish NPM history is quite short and there is not yet much experience to draw on. The municipalities are only now applying NPM related changes

and the jury is still out. NPM influences on healthcare sector include e.g. customer approach in service production which is one of those complicated issues that the public administration has to solve; how to combine public health care and private sector oriented customership.

5. HEALTH, POLICY, AND POLITICS

Both *health* and *policy* are contested terms and there are several interpretations. Therefore, before discussing health policy in a more comprehensive way, we need to define what is actually meant by “health policy” in this study.

Defining “health” is rather simple, as the most widely accepted definition is the one by WHO (World Health Organization 1948)

“Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”

The utility lies in the compact form but it is worth noting, though, that this definition has also raised criticism and discussion. It has been criticised for instance for the word “complete” and for seeing health as a state, not a process, (see e.g. Jadad & O’Grady 2008; Green & Tones 2010, p. 7-15). Nonetheless, it is the definition also used in Finland (Huttunen 2011) and therefore applicable.

For this study, the concept of *public health* is even more relevant than just health. There are, again, several attempts for definitions but the most cited is by Winslow (1920, p. 30), either as a more comprehensive or as this shortened version:

“Public health is the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community (--).”

Naturally, when discussing health, the term *medicine* appears in this context as well. The difference between medicine and public health is in the focus: medicine focuses on the health of an individual patient but public health focuses on the population.

The goal of public health is the comprehensive wellbeing of all members of society, covering biologic, physical and mental factors. The functions of public health can be expressed in different tasks and processes, which *include identifying, measuring, monitoring, surveying, formulating, promoting, enforcing, controlling, reducing, planning, administering and managing*. Public health actors also educate the public, influence policies and formulation of regulations, and in many cases also deal with environmental factors. Also disaster (e.g. epidemics, natural hazards) preparedness is an essential component of public health. Many advances have become possible through research, and the quality of research has been improved by the development of new methodologies, especially in certain fields, such as epidemiology and biostatistics. (Detels 2009, p. 3-4.)

Poverty is the underlying factor in almost all public health problems of the world, notwithstanding the economic status, and the disparity between the rich and the poor is increasing both between and within the countries. It is incumbent on public health to reduce these disparities, which affect every society as a whole, although they primarily impact the most vulnerable and poor populations. As to developed countries, public health issues concern nowadays mainly chronic, noncommunicable diseases, mental illness and challenges caused by population changes instead of communicable diseases, which prevail as the main problem in the developing world. Other public health problems deal with e.g. oral health, injuries, homicide, violence, suicide, vulnerable populations, various environmental and pollution factors, occupational health, access to and provision of healthcare, and bioterrorism and war. (Detels 2009 p. 6-16.)

Defining “policy” is a more complicated task. Policy as a concept is neither specific nor a concrete phenomenon so defining policy poses a number of problems. Policies may be described as on-going, dynamic and subject to change, and while policy is usually understood as “action”, it can be as much about inaction, “non-decision making” (see Chapter 3). Policy can also be seen as an outcome of actions taken by “low-level actors” and it can emerge as the outcome of a set of processes rather than as a formal decision to follow a course of action. (Crimson

2009, p. 7.)

The terminology used in different official documents is sometimes confusing. For instance, the Finnish word “politiikka” may refer to either “policy” or “politics”. Also words such as “programme”, “strategy”, “project”, “recommendation” or “proposal” are used in partly overlapping ways. My case is a “Government Resolution” but the MSAH refers to it as a programme. Perhaps even more confusing is that there is indeed a brochure called “Health 2015 public health programme” (Sosiaali- ja terveysministeriö 2001) which introduces the Government Resolution on the Health 2015 public health programme.

As can be seen above, there certainly are various ways to understand policy. Dye (1992, p. 2) has vigorously defined policy as “(--) *whatever governments choose to do, or not to do* (--), but of more detailed definitions I will present three, which support each other and elucidate well how policy is understood in my study:

1. “(--) *it seems useful that policy be considered as something broader than the tangible pieces of legislation and regulations which at any moment are being administered by government departments. A policy, like a decision, can consist of what is not being done* (--). Although it is common to use program and policy interchangeably, we will generally reserve the term program for these specifically enacted objects of administration. (--) *A policy may usefully be considered as a course of action or inaction rather than specific decisions or actions* (--)
(Heclo 1972, p. 85)
2. “*a policy* (--) *consists of a web of decisions and actions that allocate* (--) *values*” (Easton 1953, p. 130): quoted in (Hill 2009, p. 15).
3. Policy is “*a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of*

achieving them within a specified situation where these decisions should, in principle, be within the power of these actors to achieve.” (Jenkins 1978, p. 15)

To summarise, by “policy” this paper will refer to a synthesis of all these above:

(--) a stand taken on an issue by an organisation or individual in a position of authority. More specifically, it might refer to a statement, a decision, a document, or a programme of action. (Baggott 2007, p. 2, referring to Hogwood & Gunn 1984, p. 13-19).

Finally, there is not a single definition for health policy, either. For this study, the definition by WHO (2012) is applicable:

“Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society. An explicit health policy can achieve several things: it defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people.”

In general, health policy may cover public and private policies about health. Health is influenced by many determinants outside the health system, policy analysts are also interested in the actions and intended actions of organizations external to the health system, which have impact on health, such as food, pharmaceutical or tobacco industries. (Buse, Mays & Walt 2005, p. 5).

As was mentioned already in the Introduction, very often health policy is regarded in a narrow sense as healthcare policy, although healthcare system is just a part of health policy. The state and Government play a central role in health policy, through different mechanisms, and therefore they are typically in central focus of

(health) policy analysis. Regarding health, the state often provides or allocates health care and e.g. controls the licenses for practitioners, number, and size of medical schools, ensures safe water and food, regulates workplaces to reduce the threat of injuries and the amount of pollution, sets standards for food labelling, the level of lead in petrol, and tar and nicotine in cigarettes. (Buse et al. 2005, p. 48-49.) In addition to this list, in many countries the Government also holds the monopoly over health-related taxes.

5.1 Health promotion and social determinants of health

Health promotion is one of the key concepts in public health, and it can be viewed as an umbrella term or as a discipline in its own right (Green & Tones 2010, p.15) It was effectively launched in Ottawa Charter in 1986 (WHO 1986) and is defined as follows:

“Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.”

The father of public health, C-E. A. Winslow found the role of health education very important in improving public health, and his ideas were further cultivated by health promoters. In the 1950s and 1960s, due to improvements in epidemiology and medical care, the treatment and diagnosis of noncommunicable diseases as well as the effect of individual lifestyle factors became the focus of attention. Especially smoking as a risk factor for e.g. lung cancer rose on the public health agenda. Health education was considered a cheap public health tool and could

be combined with mass media. Therefore, in the 1960s and 1970s in many high-income countries, such as Finland, Sweden, Norway, Canada and Australia, the governments became interested in this kind of high-profile health promotion and provided the professionals with e.g. infrastructures and trained workforce. (Davies & Macdowall 2006, p. 10-12.) Non-profit organisations are still significant public health actors in many countries and their establishment is dated in the same decades.

Of different turning points in the history of public health, the Lalonde Report (1974) can be said to be a very significant one. It was the discussion opener for different functions of the government in promoting population health and also discussed limitations of healthcare sector.

During the recent years, there have emerged new public health concepts, such as "healthy public policy" (WHO 1988; Gagnon, Turgeon & Dallaire 2007) and "Health in All Policies" (T. Ståhl, Wismar, Ollila, Lahtinen & Leppo 2006). Also several different reports illuminating the different societal determinants of health have been published, such as Marmot et al. (M. G. Marmot, Rose, Shipley & Hamilton 1978), The Black Report (Department of Health and Social Security 1980), Barker (Barker 1998) and McGinnis et al. (McGinnis, Williams-Russo & Knickman 2002). A more recent one, which have raised a lot of attention and which is one of the most comprehensive papers on reducing health inequalities, is The Marmot Review (Marmot 2010). These reports clearly show that health is socially patterned and people having different socioeconomic status suffer from different health and death risks. For Finnish position and research, see e.g. Kaven-taja (THL 2012a).

The multifaceted essence of health was presented in a very compact way by Dahlgren and Whitehead (Dahlgren & Whitehead, 1991/2007).

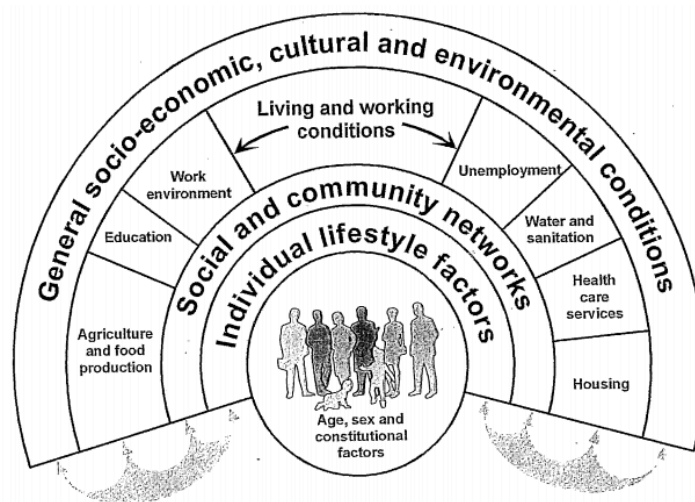


FIGURE 1. Policy Rainbow

Source: Dahlgren & Whitehead 2007, original in 1991

Their Policy Rainbow is a good presentation of how health and welfare are indeed influenced by various factors at different stages of life. One section of the rainbow is reserved for the individual responsibility but there are several others, which are affected mainly by decisions made by state, Government, municipalities and other local authorities. I do not totally agree on the proportions of the sections, although this model has been revised in 2007 from the original one, but as a general overview this model is clear and defends well its place.

WHO (2003) has defined the social determinants of health as follows: *social gradient, stress, early life, social, exclusion, work, unemployment, social support, addiction, food and transport*. The list confirms the saying "good social policy is also good health policy", which is sometimes contested but in this light seems to be quite accurate, especially through reducing poverty, social exclusion and unemployment.

5.2 Health and politics

Health and health promotion are surprisingly rarely considered to be political issues, although they highly are (e.g. Signal 1998). In many ways, decisions regarding health are related to for instance individual freedom, democracy, organization of society, the role of state, sustainable resources, working life, equality, justice,

relationship between public and private sectors, and which comes first, the interest of an individual or the whole society. Even medical professionals, when making everyday decisions, are part of this value system and Krakauer (1992) reminds his colleagues in the medical community to be aware of the context where also their work is placed. The nature of health issues raises also the ethical question who is to be listened to in situations where there may be several conflicting interests, e.g. of industry, an individual or health professional. This leads to the responsibilities of politicians and civil servants; the decision making and societal processes must be transparent to allow voters to see whose interests are at stake.

Due to the political nature of health, it is important to extend the analysis to political institutions to better understand global health inequalities. There are not many studies on the relationship between political institutions and health, probably because the relationship is quite complicated and it is not easy to find causalities between different factors. The relationship can be defined in many ways, ranging from the study of political systems, culture, institutions, state capacity, political process factors, personal politics, political strategy and interest group presentation. Recently, Ruger (2005) has studied the re-election incentives and financial contributions and their influence in the US. She has also investigated the democratic principles in China and she states (*ibid.*) that democratic institutions and practices can affect human development in multiple ways, including well-being and population health, and especially the absence of democracy can have detrimental effects on health.

As was mentioned already in Chapter 2, there has lately been a growing demand and need for public policy analysis in the health research and also for political science approach and investigation of political determinants of health and health promotion (e.g. Bambra, Fox & Scott-Samuel 2005; Bernier & Clavier 2011; Raphael 2003; Breton & De Leeuw 2011). Navarro et al. and Bambra et al. (Navarro et al. 2006; Bambra et al. 2005) wonder why very few scientific studies have analysed the consequences of the political agenda, institutions, political variables and the public policies of political parties and movements for the health

of population and social inequality. They find this shortage of research surprising because in democratic countries politics supposedly determine public policy. Bernier and Clavier (2011) accurately write that generally speaking the bulk of policy analysis in public health research is largely concerned with measuring and evaluating policy impacts but pays little attention to the policy making process, and researchers have an idealistic and narrow view of public policy and the research too often relies on an implicit linear model of policy making. They argue that most researchers of public health aim at influencing public policies through the formulation of recommendations about what kind of actions the authorities should take and that researchers concentrate largely on the current contents of health policy. Bernier and Clavier (*ibid.*) claim that researchers' main interest lies in measuring a given outcome (e.g. if the quality of indoor air has changed or what is the cost-effectiveness of a policy instrument) and public policy is seen as being external to public health research. However, knowing how the political system works and how decisions are made would be useful, even essential, to both scientists and public health professionals (Oliver 2006).

To summarise, Bambra et al., (2005, p. 187) have outlined why they see health to be political:

- "Health is political because, like any other resource or commodity under a neo-liberal economic system, some social groups have more of it than others
- Health is political because its social determinants are amenable to political interventions and are thereby dependent on political action (or more usually, inaction)
- Health is political because the right to "a standard of living adequate for health and wellbeing" (United Nations 1948) is, or should be, an aspect of citizenship and a human right"

They conclude that health is political in essence because power is exercised over it as part of a wider political, economic and social system, and if one wants to change the system, political awareness and struggle are needed.

If that is the way things are, why has health perhaps been regarded as apolitical and not discussed as a political entity even within academic debates? Bambra et al. (2005) believe that there is no simple answer because issues and their interaction are complex. Nevertheless, they do present a couple of aspects. First of all, health is often regarded and misrepresented as healthcare, and the discussion is mainly about which provider should be responsible for the services: government or private health market. Also, the definitions of health and politics can be one cause for the apolitical role; as is shown already earlier in this chapter, health can be understood as the absence of disease and as a commodity – both approaches focus on individuals.

I would like to add to this analysis that health may also be regarded as a “restricted” subject that only belongs to the health professions, which makes political discussion challenging, especially if value conflicts or strong emotions are involved.

In addition to political and ethical (e.g. Kuusi, Rynänen, Kinnunen, Myllykangas & Lammintakanen 2006; Valtakunnallinen terveydenhuollon eettinen neuvottelukunta ETENE 2008), health promotion and related factors, such as obesity, are also very sensitive issues (e.g. Tynkkynen 2009). As a result, health-focused discussion encounters also criticism. Concerned observations and demands for individual behavioural change can easily be called health enthusiasm or even “health Nazism”. Some commentators criticise the growing focus on individuals and blaming the “victims” instead of solving the societal problems. Although the purpose of focusing on social determinants of health is to decrease health disparities, the critics have a legitimate point in their claim that health promotion may in fact and in some cases increase differences if only the advantaged people have access to services and e.g. healthier nourishment. The fourth main point of critique is directed to professionalism; especially in the Western welfare societies, health is an extremely popular issue right now and health promotion can be seen to belong to the expertise of only a narrow class of health (care) professionals leaving no room for ordinary citizens or professionals of other

discipline. (Davies & Macdowall 2006, p. 95-96.) While I find the critique legitimate, as there have been health projects which have not been that successful, I still see that e.g. playing the Nazi card, so to speak, is a too simple way of ignoring this important topic. Also, health disparities can be reduced by conducting projects and interventions better to increase their efficiency and effectivity in the right target group. Finally, making sure that the societal decision making is as horizontal and diverse as possible and all the relevant actors are included, it is possible to reduce the narrow(er) viewpoint of just few professions.

5.3 Health policy and party politics

There has not been very much research either on how the political composition of governments and political parties affect executed health policy and public policy choices. Navarro et al. (2006) analysed a number of political, economic, social, and health variables over a 50-year period in a set of wealthy OECD member countries, Finland was also included in the sample. They were able to make an empirical link between politics and policy, and their results showed that political parties with egalitarian ideologies tend to implement distributive policies and policies aimed at reducing social inequalities seem to have beneficial effect on some selected health indicators, such as infant mortality. According to their study, social democratic parties have tended to introduce redistributive policies that are positively associated with health outcomes and especially support women's health and wellbeing, e.g. unemployment compensation for single mothers, women's labour force participation and early child education. They also found the strongest relation between politics, policies, and health outcomes to appear when considering long, cumulative years of government by political parties. Navarro and Shi (2001) also investigated the same theme and they found that political variables, such as the political party in government either alone or as a majority partner, for longer periods of time are important in influencing a country's level of income and social inequalities and its health indicators. According to the study, labour movements and social democratic parties that have governed as a majority for long periods since World War II have generally been the most committed to redistributive policies, which has contributed to better health indicators.

When comparing states, different classifications may sometimes cause problems and depending on the study, e.g. Finland has been defined as social democratic, Nordic, Scandinavian or corporatist country.

The Finnish experiences are compatible with these results. There have been 72 different governmental coalitions, minority or majority, since declaring the independence in 1917. The Social Democratic Party (SDP) has either been the prime minister party or otherwise participated in 35 of them. Since 1972, when the Public Health Act came into force, SDP has been eight times the Prime Minister party and in 13 coalitions altogether. (Finnish Government 2012) SDP was the Prime Minister party also during the years 1995-1999 (Lipponen I) and 1999-2003 (Lipponen II), when the Health 2015 process was started [1997] and when the programme was published [2001].

5.4 Evidence-based health policy making

Modern healthcare and practice of medicine is strongly grounded on evidence-based decisions.

- **Evidence-based health care** is the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services. Current best evidence is up-to-date information from relevant, valid research about the effects of different forms of health care, the potential for harm from exposure to particular agents, the accuracy of diagnostic tests, and the predictive power of prognostic factors (Cochrane 1972)
- **Evidence-based medicine** (EBM) is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. (Sackett, Rosenberg, Muir Gray, Haynes & Richardson 1996)

Partly due to demands for economic efficiency and rising costs for health care, there have been claims also for evidence-based health policy making. Especially in the last decades, the need for "better" or "the best" solutions and arrangements, advantages and disadvantages of different choices has grown due to a European-wide wave of health system reforms. This development can also be seen tangential to the penetration of NPM (Head 2008), especially regarding health targets (see Chapter 5.5). While national systems differ to some extent, the policy makers and experts have sought for answers and made decisions based on the experiences in other countries or geographical areas. (Mossialos, Dixon, Figueras & Kutzin 2002.)

In political science and policy studies, the rational decision making model has this kind of approach (e.g. Hamlin 1986; Lehtinen 2006; Pakarinen 2011; also Chapter 3.1). The premise is that scientific knowledge and rational thinking lead to best possible results. It also sees decision making and e.g. preparation of a policy programme as a logical, linear process with separate stages. After defining the problem or current situation, the decision makers will find the best possible solution by comparing different alternatives and taking advantage of the best possible scientific knowledge available. After legislation, a programme or other desired result has been put into force, the decision-makers evaluate the situation, and based on the analysis, they will make adjustments or start a new process. Especially health policy and healthcare decisions seem to be a very natural framework for these kinds of demands because in the clinical and medical practice the evidence-based approach has been successful and well accepted. In Finland EBM is put into practice by Current Care Guidelines [Käypä hoito] (Duodecim 2012).

However, this evidence-based mindset has also met opposition. The critics say that demands for evidence-based policy making reveal that the scholars do not understand the reality of political decision making; that decision making is not purely based on facts but always include politics. Especially evidence-based health policy making would be problematic because public health problems are

often caused by many factors and changes take a long time; if decision-makers would wait for evidence of all the interventions or chosen policies, there would not be much a politician or a decision-maker could do. For instance, the former Director-General with the MSAH Kimmo Leppo (2009) has commented that in principle health policy does not crucially differ from other public policy fields scientifically or regarding its actions. According to Leppo, the question is about aims, resources, political environment and instruments as well as the processes of political decision making, implementation and evaluation. It is also about institutions, political power, professionals and interest groups at different levels, from local to global actors. Leppo continues that all policies are based on two elements: values and knowledge, and values can be explicit or implicit. There is no politics without values, although politics may sometimes be presented neutral or value-free. In addition, making health policy is affected also by how health is understood: as an intrinsic value or only having instrumental value. Leppo states that health policy is very rarely based on purely evidence-based thinking and he says it is not right to even expect that. Instead one should be humble and admit that *"policies are driven by values and power, hopefully informed by evidence"* (Leppo 2008).

From the health inequality viewpoint, Nutbeam and Boxall (2008) have investigated the role of evidence in policy making in the UK and Australia and what influences the transfer of research into health policy and practice. They found that public health evidence does indeed have the capacity to influence Government's policy responses, but it requires public health practitioners and advocates to understand policy making processes and to participate in them, and presenting research in a way that fits with the "political context of the day". This view is compatible with Kingdon (see Chapter 2.2.2).

To bridge the gap, there have been some attempts to raise discussion and find the potential for increasing cooperation between scientist and political decision-makers, and also to recognise the possible disconnections (e.g. Hyder et al. 2011; Jansen, van Oers, Kok & de Vries 2010). One of the best, and also surprisingly

entertaining, papers is from Choi et al. (2005). It is obvious from the beginning that the writers know both science and politics. While their suggestions are very welcome and partly also useful, unfortunately I found the text (again) to be a bit too much health care centred. I also started to wonder if their ideas of chief executive officers (*ibid.*, p. 635) and translational scientists are realistic. In a way, I liked very much the idea of a mediator but especially in larger organisations it may be too challenging to find someone who would be an expert on little bit this and that. Having said that, I highly appreciate their say.

A very recent and very interesting evidence-based policy making model is from the UK Cabinet Office Behavioural Insights Team (Haynes, Service, Goldacre & Torgerson 2012). They are developing a model which would apply randomised controlled trials (RCT) for investigating public policy interventions.

5.5 Targets in health programmes

Setting health targets has been one way of executing evidence-based policy making. Already since the World War II the universal access to healthcare and social insurance have been policy goals in most Western countries, and targets for health policy have existed concurrently. However, they were introduced to public policy more systematically by WHO in 1984 (WHO 1993). Since, health targets have become widely used instruments to promote population health, especially in Europe (e.g. Loes M Van Herten & Van de Water 2000). The targets are designed to improve health and health system performance, they may be quantitative or qualitative, and they may be based on health outcomes or processes (Smith & Busse 2010). They may also be set at any level, and be national or e.g. regional. Health targets will enable the Government to provide leadership and strategic direction for health sector but also make them accountable for their activities; through evaluation, the Governments and organisations can be put to bear the political responsibility for their choices. Therefore, it is very important that the stakeholders are committed to the implementation, monitoring as well as evaluation of solutions. (Van Herten & Gunning-Shepers 2000.)

Targets in the context of health policy are not straightforwardly a simple tool to apply. As Gunning-Schepers and Van Herten (2000) point out, it may be a political risk to create explicit targets in a field where it is impossible to control all the relevant determinants and the problems are met in terms of data availability and epidemiological methodology. Besides the long timeline for many public health problems, many of the most important diseases also have several risk factors and on the other hand many risk factors affect several diseases. Therefore translating epidemiological data into realistic policy targets may be problematic. One additional piece of the puzzle is that besides the various non-healthcare related issues that can affect health, the health policy administration may also be devolved from the central government to regional governing bodies, as Wismar et al (2008) point out. Their report is the most recent overview of health targets in some European countries and Russia. According to them (ibid.,p. 13), countries, even the most individualistic ones, have always agreed to some extent that there is a justification for the state to intervene in health improvement. It is currently understood that this must be done in a coherent way and by recognising the challenges that many people face when making their everyday healthy choices. State intervention must also be based on evidence of effectiveness and it should be accompanied by measures that will allow it to work. Wismar et al. (ibid.) note that to make this kind of intervention possible through a national health strategy assumes that society as a whole has an interest in the health of the individuals comprising it.

There have been a fear of lack of political commitment on health targets but according to Gunning-Schepers and Van Herten (2000) the targets have survived the changes of government and political parties in many countries. Consequently, many health targets seem to make sense apart from the individual minister or his/her political ideology. Nevertheless, one problem regarding health targets derives from the relationship between health policy makers and professionals working in healthcare. It seems that in many countries these groups are not the same. Gunning-Schepers and Van Herten (ibid.) write that due to the link between use of health targets and "Health for All" policy, of which the investigators comment that the approach has been "almost ideological", the health targets were never

really integrated with management objectives and health services. Gunning-Schepers and Van Hertten state that because of the great emphasis on health promotion, prevention and intersectional action, many people working in the healthcare sector have felt that (curative) health services are not seen to be beneficial to the health of individuals anymore, and the everyday services for ill patients have not been acknowledged. Thus, the writers believe that emphasis of health improvements may have alienated the health policy makers and healthcare professionals from each other, which has also been accentuated by the discussion about rising healthcare expenditures and a need for system reform.

I partly agree with Gunning-Schepers and Van Hertten, but I see the problem existing perhaps more in the lack of well-defined and planned health policy and also in the absence of a common language. If healthcare sector and “the other sectors” are seen separate from each other and if there is not a common understanding of what is meant by health promotion, the scarce resources will be wasted. In terms of political decision making; if there is not enough or eligible expertise, targets may be defined in a way which is not achievable or even plausible in the eyes of healthcare sector. This will cause frustration and mistrust, and it is unsatisfactory for politicians, other decision makers, and for healthcare professionals.

Wismar and Busse (Wismar & Busse 2002; Busse & Wismar 2002) have arrived in the same conclusion than Gunning-Schepers and Van Hertten in their analysis of policy documents of national and regional health target programmes in countries of the European Union, Australia, Canada, New Zealand, and the USA. They see that there is a division between health policy, which is mainly concerned about managing the costs, and on the other hand the “other” health policy, which is committed to “Health for All” and those health target programmes, which derive from WHO. Busse and Wismar (2002) write that health policy in industrialised countries is by far concerned with economic interventions, while at the same time a lot of scientific, intellectual and managerial effort is put to identifying priority areas for improving health outcomes. They comment that the debate about health targets has evolved separately from the discussion on healthcare reform and

health services. As a striking example they mention the WHO-EURO's Ljubljana Charter on Reforming Health Care (World Health Organization - Regional Office for Europe 1996) and the accompanying volume (Saltman & Figueras 1997) which do not mention health targets at all. This is indeed a quite remarkable observation considering that WHO is the organization which has introduced the health targets in the first place.

As a conclusion, Busse and Wismar (2002) state that health policy reform debate has neglected to learn from the experiences of health target programmes and vice versa. They also claim, referring to their earlier research (Busse & Wismar 1997) that many national and regional governments, which have introduced health target programmes, try to avoid any interference with health services. The writers mention that one viewpoint, which they find particularly outstanding, is the absence of financing from all health target programmes. They say this is even more astonishing considering, as mentioned above, that the key issue in the healthcare reform discussion in the past two decades has been precisely cost-containment. The economy vs. health in societal appreciation was noted also in Marmot Review (Marmot 2010) and it states that while economic growth is not the most important measure of a country's success, actions that are taken to reduce health inequalities will indeed have economic benefits as well. Therefore, from economic perspective, investing in health is investing in the future prosperity of a country.

In their study, Wismar and Busse (2002) noticed that most, if not all health target programmes are conceptualised in a "top-down" manner by the government. They discovered the complete absence of national and regional parliaments in the decision-making process regarding health target programmes and very little involvement of the general public. They see the lack of parliamentary influence to be a political phenomenon and interpret that to explain the low status of health target programmes. In their analysis, Wismar and Busse (ibid.) found that there are two main reasons behind developing health target programmes: they reflect the experience with previous programmes and new challenges have required appro-

priate responses. Also they noticed a trending shift towards health promotion, disease prevention and increasing recognition of cost-effectiveness, which may reflect the financial pressures put on health services in all industrial countries.

As a conclusion Wismar and Busse (2002) claim, maybe in a slightly provocative tone, that any health target programme is a highly political affair and the scientists must be aware of this and be able to make compromises. Also they claim that most programmes are bound to fail if they follow the political strategies that are defined in the policy documents, and some programmes seem to serve only as good PR for a ministry to improve its image. According to the study, some programmes are made just to keep the critics of health policy busy, the instruments that are used the most are based on voluntarism and goodwill, and most programmes end up never being “owned” by those who would put it into practise. Wismar and Busse (ibid.) also wish that WHO would reconsider its role, and instead of standardising the outcomes in the form of set health targets, it should rather support political processes at national, regional and local levels.

While I see that Wismar and Busse have a fair point in their allegation that many health programmes are merely PR and in global context perhaps even public diplomacy, I have a more positive view on political decision making and of the potential of programmes and political strategies. It is true, however, that at least in Finland the instruments are mostly based on voluntarism and goodwill, which may cause problems. On the other hand, I believe that there is still something to be done about that, for instance to focus on leadership, to engage the essential actors, and to plan processes and desired results better. Thus, I agree with Wismar and Busse in their wish regarding WHO to change its focus from standardised targets towards supporting processes.

5.6 International actors influencing health

As was shown in the beginning of this chapter, state of health is influenced by many factors. During recent decades, the world has changed and it has become more complex; at the moment we are living through a major transition in the

health of populations. People live longer, fertility rates are declining, human mobility has increased, and the burden of public health problems has switched from communicable diseases to noncommunicable and chronic diseases, especially in developed world. Also lifestyle-related disorders have grown in number, such as lung cancer (mainly caused by smoking), type 2 diabetes, and hypertension which is the leading cause of cardiovascular disease (CVD) worldwide (Hajjar, Kotchen & Kotchen, 2006). The state and prospects of public health both in developed and in developing world depend largely on the processes of globalisation, especially on the emergence of global environmental changes and events in the world economy (see e.g. McMichael & Beaglehole 2000.)

The main international actors from global public health point of view are World Health Organization (WHO), United Nations (UN), World Trade Organization (WTO), World Bank, United Nations Educational, Scientific and Cultural Organization (UNESCO) and International Monetary Fund (IMF). From European perspective, the European Union (EU) has significantly increased its role also in health policy, especially regarding private healthcare services, although its role and influence in health policy have also been questioned (e.g. Greer 2011; Koivusalo 2010; Ståhl 2009; Keskimäki 2007; Duncan 2002). In addition to governmental organisations, there are also many nongovernmental organisations and transnational corporations of various fields whose activities may have significant impact on health, either making it better or damaging it (e.g. Abbott 2005; Birn & Dmitrienko 2005; Ruger 2005b; Stuckler et al. 2010.)

In terms of Finland, the most important years and events regarding WHO and WHO Regional Committee for Europe have been listed below.

1978	Health for All Strategy International Conference on Primary Health Care / Declaration of Alma Ata
1981	Global Strategy for Health for All by the Year 2000

- 1984** Health for All Targets

- 1986** The Ottawa Charter for Health Promotion
 Health for All by the Year 2000: The Finnish National Strategy

- 1990** European Strategy Health for All by the Year 2000

- 1993** Health for All by the Year 2000: the Revised [Finnish] Strategy for
 Cooperation

- 1998** HEALTH21 – European Health for All in the 21st Century

The role of the EU in health policy is interesting because public health issues of the Member States belong to national competence and therefore the actions of the EU shall only complement them (European Union 2008, p. 122-124). Also Article 21 in Treaty on European Union has been seen to apply to health (European Union, 2008b)

However, since the Lisbon Treaty came into force, the Member States have been obliged to coordinate their positions before e.g. WHO meetings, such as the World Health Assembly. I have contacted the MSAH, the MFA and the Europe Information, but I have not been able to receive confirmation on why the coordination exists and there seemed to be uncertainty of the reasoning.

However, the House of Commons in the UK has referred to Lisbon Treaty Article 1 35 (House of Commons 2007) and summarised the changes as follows:

“Consultation among Member States in order to ‘determine a common approach’” and “Member States to consult each other before undertaking any action or commitment which could affect EU interests.”

In my understanding, however, these requirements concern Common Foreign and Security Policy and while some public health issues, such as serious epidemics or defective groceries, may be considered as a direct threat to national and international security, it is only a fraction of the whole health field.

It seems, therefore, that the role and influence of an individual Member State, excluding the Presidency, both in WHO and in the EU, has changed, even decreased, due to the demands of consensus. As the function of the EU has economic and trade focus, not health political, due to this custom change there is a real danger that the mandate of the EU is incrementally increasing also in health affairs and the decisions are affected more by the interests of industry and economy than public health. For the EU and industry, see also Chapter 7.3.

6. FINNISH HEALTH POLICY

In this chapter, I will focus on events, actors and phenomena that form Finnish health policy. They are in many ways in unison with the previous chapters, and some events and details have been already referred to in respective contexts. However, the aim of this chapter is to offer a more comprehensive understanding of how health policy has been understood in Finland, which actors are and have been important, how the international health policy community has affected Finnish health policy and finally, what is the status of public health education and research in Finland. As was noted already in the Introduction chapter of this study, my focus is not on healthcare systems. However, as Finnish health policy cannot be understood without knowledge of the historical background of healthcare structures and the Finnish welfare state, these themes will be addressed in this chapter as well.

6.1 Definition of Finnish health policy according to literature

The main objectives of Finnish health policy stem from Kari Puro's dictum in his well-known Principles of health policy from 1973 (Puro 1981, p. 45). The objectives can be divided as follows, according to Melkas, Lehto, Saarinen and Santalahti (2006):

1. to secure the best possible health for the population
 - to reduce premature mortality
 - to reduce illnesses, accidents and related impairments of functional capacity
 - to maintain highest possible level of physical, mental and social well-being in the population
2. to minimise disparities in health between different population groups i.e. to make sure that health will be distributed evenly in the society
 - to promote health most particularly in those groups with the poorest health

Various societal policies affect, whether intentionally or not, disparities in health either positively or negatively. Koskinen, Sihto, Keskimäki and Lahelma (2002) have observed that in Finnish health policy, there seems to be a constant tension between these two main objectives. So far, the entire population has been considered as target population, but the scholars argue that this policy seems to be unsuccessful in reducing socioeconomic differences in health. Thus, need-based activities and limited interventions have been discussed as an alternative.

6.2 Historical background and present day

The Finnish healthcare system has gradually grown during the decades and is the result of several structures and origins. Also the statutes regulating public health have been passed separately and layered, so they have not necessarily allowed systematic public health planning and they have often been incompatible with changing conditions (Suonoja 1992; Mattila 2011, p. 342-3). Therefore, a certain level of illogicality is built in. One of the features in Finnish healthcare system has been the strong position of public healthcare services. However, this public share has only started to increase after the World War II. In the beginning of the 20th century the state was not involved, which has often been explained by poverty and exceptional circumstances but it has been also consistent with the contemporary political ideology of the bourgeois right wing parties holding power. (Wrede 2000, p. 189; 191.) Municipalities have been responsible for promoting the health of the citizens already since the mid-1800s (Ståhl & Rimpelä 2010) and the relations between municipalities and the state started to take the current shape already in the 1920s. The mandate of municipalities was seen originating from the state and regarding services, an early orderer – producer model can be seen to have been born: state financing the health services that municipalities produce for their citizens (Wrede 2000, p. 192; Pulma 1996, p. 16).

Different periods and “stages” of public health development have naturally been partly overlapping. E.g. Minna Harjula’s (2011; 2006) categorisation is very applicable:

YEARS	1880-1940	1920-1940	1940-1950s	1960s	1960s-1980s	1990s→
MAIN POLICY	Hygiene	Racial hygiene	Population policy	Health service policy	Societal policy	The policy of freedom and responsibility of an individual
FEATURES	Education, life style, environment	Genotype, biology	Family, authority of biomedicine, belief in technology	Health services, authority of biomedicine, era of growth	Societal conditions, demands for comprehensive health policy, authority of biomedicine, prevention, health promotion	Individuals, economy, medicalization, authority of biomedicine, social determinants of health, customers, health promotion, media

FIGURE 2. Adapted from Minna Harjula’s presentation (2011) and Kovero, Itkonen & Partanen (1986, p. 134) in Suonoja (1992, p. 517). Based on my research, I have added some features in the category from the 1990s onwards

The public development in the late 1800s and the early 1900s can be seen to have followed quite well the international model: the earliest stage of public health being about preventing epidemic, such as tuberculosis, and focusing on sanitation, clean water and healthy home environment. Various women’s organisations have been extremely important in educating families (see also Chapter 7.4).

The first half of the 1900s was also influenced by wars, and e.g. during 1939-1945 there were over 95 000² deaths and there was a need to orient to population growth instead of population “breeding”. After the World War II, also systematic vaccination programmes were organized e.g. against tuberculosis, and vaccines against smallpox, typhoid fever, cholera and diphtheria were offered already earlier (Peltola 2000).

² <http://kronos.narc.fi/menehtyneet/>

In the 1940s, the idea of '*kansanterveys*' was introduced more systematically, although the idea was born already earlier (also Rimpelä 2010; 2005). The term does not have an exact English translation: it is more than just public health but "nation's health" is not totally correct, either. The concept of *kansanterveystyö* means taking comprehensively care of the health of the whole population regardless of age, location, social status or gender and the idea was fully blooming and implemented in the 1960s and 1970s (Harjula 2006; 2011). Already in the end of the 1950s, the future of public health and the content and structure of *kansanterveystyö* were in the focus of discussion and a committee was established to prepare a new law. However, the medical profession was not very much involved. The physicians concentrated on their work in the hospitals and there was also lack of information how the new legislation would change the position of the profession. (Suonoja 1992, p. 515.)

Among important changes were e.g. introducing legislation of general medical care (1943), and creation of a network of statutory maternity and child health clinics in the mid-1940s (also Teperi & Vuorenkoski 2006). In 1949, the prerequisite of receiving maternity allowance was connected to visits at the maternity health clinics. This reform meant a closer relation between social and health policies and on the other hand brought families into healthcare system in a comprehensive way. One significant and pioneering innovation regarding families and healthier population was the system of free school meals which have been served since 1948.

The chronic diseases were not taken into account very much after the war, and they were mainly addressed by several disease based NGOs, such as the Cancer Society of Finland, the Finnish Rheumatism Association, The Finnish Heart Association and the Finnish Diabetes Association. Only in the 1960s, also chronic, noncommunicable diseases were recognised and rose on the agenda of Finnish health policy. (E.g. Harjula 2006, p. 104; see Chapter 7.4 for NGOs)

Already during the war there was reorganisation of temporary hospitals and units, which gave more power to the National Board of Health, as there was need for centralised coordination (Wrede 2000, p. 194). At that time, it was administrated

under the Ministry for Internal Affairs. Initiated by the National Board of Health, the active members of the Finnish Medical Association (FMA) began to plan both state and municipal hospitals. The role of medical profession and the FMA has been significant in many ways, see e.g. Saarinen (2010) for more detailed discussion.

The founding and development of general hospitals began in the 1950s, and between 1950-1969 the number of beds increased almost threefold. The running of general and psychiatric hospitals was taken over by local municipalities in the 1950s as well. (Teperi & Vuorenkoski 2006.) Regarding hospitals, the division of responsibilities between state and municipalities was problematic and the network of hospitals was varied; besides state and municipalities, there were also hospitals owned by private actors and municipal alliances. All in all, the general hospitals have become a crucial part of Finnish secondary health care but at the same time they are the source of tension regarding the needs in primary health care. (Wrede 2000, p. 195.) For instance, in the 1950s and 1960s hospitals accounted for the bulk of healthcare spending and still in the end of 1970s the secondary healthcare took 90 % of the resources (e.g. Teperi & Vuorenkoski 2006; Wrede 2000). In the 1960s, the growth of healthcare expenses was almost double as much as the growth of GNP, caused by the increase in the amount of hospitals mentioned above. Still today, the structure and ownership of hospitals and the organisation and funding of secondary care vs. primary care are causing several problems for municipal budgeting.

Although the costs were increasing, the local health differences were worsening. Especially in the Northern and Eastern Finland the mortality and morbidity rates were higher than the rest of the country. As a result, it was seen that improving the hospital-related healthcare is not enough to promote the health of population. There was a need for systematic, national priorities and determined health policy, which would control the resources and operations. (Suonoja 1992, p. 518-9.)

At that time, there were various reasons for the imbalance between primary and secondary care, and the need for examining the relationship between the work done in hospitals and on the other hand health promotion through *kansantervey-*

styö started to grow in the 1960s. There was e.g. shortage of doctors and three new medical faculties were established in 1960-1972 (Teperi & Vuorenkoski, 2006). One significant reform was the Sickness Insurance Act (1964), which was actually opposed by the FMA (see also Immergut 1990;1992) but it finally passed due to a stronger position of social policy and the changed stance of the Agrarian League [now: The Centre Party] (Wrede 2000, p. 198-9). The FMA was not the only party objecting the creation of state-operated health insurance system: there was a lot of fluctuation among political parties, the National Coalition Party being the greatest critic (Suonoja 1992, p. 471-2).

At present, the most heated arguments regarding health insurance system address the fees that should be covered, and especially private doctors' fees divide politicians and parties. Then, this discussion has existed since the creation of the system. Critics claim that it is not fair to use taxpayers' money to support private, sometimes even global, companies which do not have incentive to decrease their fees due to public financial support. On the other hand, it has been said that regarding the problems that the public healthcare system is suffering from at the moment, the citizens would not have proper care without private sector. Therefore, to make the private sector services accessible also for those with lower socio-economic status, public compensation has been seen as legitimate.

Between years 1950 and 1971, there were 73 initiatives and 7 written parliamentary questions on health care. The most active parties were the Social Democratic Party (SDP) with 40% and Finnish People's Democratic League (SKDL) with 28% of the acts. The National Coalition Party's share was 19% and the Agrarian League's / The Centre Party's respectively 14%. (Suonoja 1992, p. 519.) There were also several party political health programmes but as Suonoja (1992, p. 520) points out, the differences were mainly ideological and the programmes did not present any means or implementation plans.

In 1968, health affairs, including the National Board for Health, were transferred from Ministry for Internal Affairs to the Ministry of Social Affairs, and one of the most consequential reforms was born: Ministry of Social Affairs and Health. This institutional combination was discussed during some interviews as well and ap-

parently, even if in Finland social and health affairs have been seen to belong together quite naturally, there are still differing opinions and other preferences.

In the 1960s and 1970s, the two most influential publications affecting public health and societal thinking were Pekka Kuusi's "Social policy for the sixties" in 1961 (Kuusi 1968) and Kari Puro's "Principles of health policy" in 1973 (Puro 1981). Kuusi discussed societal policy and its general aims and he writes (p. 28) that societal policy is aiming for the best of a citizen, and accumulation and equalising of national income. He described (p. 5) societal policy to be a continuous compromise between "your" and "my" objectives. Kuusi considered healthcare policy as just one part of societal policy complementing e.g. housing, social care and employment policies. Kari Puro's important contribution included e.g. a statement that in societal policy, health is an aim as such, not just instrumental for obtaining other objectives. He saw that the main purpose of health policy must be prevention of diseases and illnesses.

In the end of the 1960s and in the beginning of the 1970s, also the perception of illness and disease was changing. Traditionally, medicine sees difference between a disease or disorder and sickness or illness, and to exaggerate a bit, it can be said that earlier the understanding was that if a person was not diagnosed with a disease, he/she was healthy, no matter how sick he/she felt. However, the new Chief of Staff with the MSAH (1972-1990), Kari Puro re-examined the concept of "health" and "sickness" in the health political and medical discourse. Having a degree both in medicine and social sciences, Puro was interested in a sociological approach of health, which for its part also affected the focus of the MSAH. Also the contemporary head of planning with the MSAH, Tapani Purola understood sickness in a broader way as a state in which an individual is more or less unable to perform daily tasks. (Suonoja 1992, p. 515-6.)

Public health NGOs and high officials with the MSAH were among the leading supporters and promoters of the idea of *kansanterveys*, and at that time it was typical that the most visible civil servants were both medical doctors and social scientists. Several officials were also politically committed, mostly close to SDP, especially since the 1970s (see also Chapter 7.1).

The changing societal thinking led to the Public Health Act in 1972 (1972/66). The Act has been described to be the most significant healthcare reform of the post-war period. For more detailed discussion, see e.g. Suonoja (1992, p. 520-533) and Yrjö Mattila (2011 p. 139-151). The Public Health Act was the starting point for municipal health centres, and the prevention of illnesses became the core aim of Finnish health policy. The new law changed the focus and tasks of municipal healthcare. As has been mentioned, the local authorities have been responsible for citizens' health since the end of 19th century, and municipalities have produced services that the state has ordered. These services consisted mainly of tasks relating to e.g. hygiene, prenatal care, child health clinics and midwifery. The new law shifted the focus towards health care and medical treatments, and the operation became disorder-oriented and the role of community-level work diminished. (Ståhl & Rimpelä 2010.)

Nowadays, the Finnish primary healthcare system consists of health centres, private clinics, the Finnish Student Health Service (FSHS), occupational health care and outpatient clinics.

Other new regulations that are important in this context, were the Tobacco Act (1976/693) and ban on alcohol advertising (1976). Until the 1970s, the individual sectors of Finnish health policy were improving gradually. From the 1970s onward many public policy sectors started to pay attention to health related matters and health promotion, but the idea of Health in All Policies (HiAP) and a more comprehensive healthy public policy started to expand only in the 1980s.

The most apparent feature of the 1990s was the economic recession which has been discussed already in Chapter 4. Another substantial change was the Finnish membership in the European Union in 1995. There are different interpretations whether the decision for Finnish membership happened "overnight" following the Swedish decision or if it was just a natural continuum to the Finnish foreign policy. Anyway, this discussion is not relevant for my study and I will not go deeper into that. What is important, however, is how the European Union influence Finnish health policy and this reality appeared constantly in my interviews as well. Especially differing views on alcohol related legislation and regulations have

caused friction and were mentioned, the most known example being the decision on decreasing alcohol taxation due to the membership of Estonia in 2003. Critical and observant viewpoints have been presented e.g. by Kimmo Leppo (2010a, p. 85-91), Eeva Ollila (in Rimpelä & Ollila 2004) and Melkas, Lehto, Saarinen, and Santalahti (2006).

There has not been, understandably, any profound analysis on what are the characteristics and themes of Finnish health policy in the beginning of the 21st century. Matti Rimpelä has drafted some future scenarios (in Rimpelä & Ollila 2004) and based on my research, I would like to add some keywords, such as “project”, “plan”, “electronic media”, “incoherence”, “bouncing”, and “drifting”.

As I wrote in Chapter 4.3, in the 1990s and 2000s, there has been an innumerable amount – even hundreds – of public policy programmes, projects, recommendations, reports and other documents. Unfortunately, there is no single resource or database which would list them all or show how they are interconnected. Most of the material or references are available in various sections either on the website of the MSAH or THL. Rimpelä, Saaristo, Wiss, and Ståhl (2009) and Kiiskinen, Vehko, Matikainen, Natunen, and Aromaa (2008) have systematically listed and analysed applicable legislation, recommendations and programmes, the latter including also comprehensive epidemiological research analysis. Thus, only the most relevant in the context of my paper and worth mentioning here are listed below:

- Health for all by the year 2000. The Finnish national strategy. (Sosiaali- ja terveysministeriö 1986)
- Health for all by the year 2000. Revised strategy for co-operation. (Ministry of Social Affairs and Health 1993)
- Government Resolution on Health 2015 public health programme. (Ministry of Social Affairs and Health 2001)
- National Health Care Project 2002-2007. (Metso, Uusitupa, Nyfors & Väistö 2008)

- Quality Recommendation for Health Promotion. (Sosiaali- ja terveystieteiden ministeriö 2006)
- Policy programme for health promotion 2007-2011. (Finnish Government 2007)
- Health inequalities in Finland. Trends in socioeconomic health differences 1980–2005. (Palosuo et al. 2007)
- National Action Plan to Reduce Health Inequalities 2008-2011 (Ministry of Social Affairs and Health 2008)
- Evaluation of health promotion opportunities – effectiveness and cost-effectiveness. 2008 (Kiiskinen et al. 2008)
- National Development Plan for Social and Health Care Services. Kaste Programme 2008-2011. (Sosiaali- ja terveystieteiden ministeriö 2008)
- Social and Health Review (given every four years to the Parliament, latest in 2010) (Sosiaali- ja terveystieteiden ministeriö 2010)
- Socially sustainable Finland 2020. Strategy for social and health policy. (Sosiaali- ja terveystieteiden ministeriö 2011)
- National Development Plan for Social and Health Care Services. Kaste II Programme 2012-2015. (Sosiaali- ja terveystieteiden ministeriö 2012)
- External evaluations by WHO (World Health Organization 1991; 2002)

In addition, there are several programmes which are disease-oriented, such as cancer, diabetes, asthma, mental health, and substance abuse.

Also the amendment of the Constitution of Finland (731/1999, chapter 2, section 19) refers to health promotion and equal distribution of health and social services:

“ (–) The public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population. (–)”

Finally, one interesting aspect in (Finnish) health policy has been the changing rhetoric and used terminology. Matti Rimpelä (2005) argues that in the beginning of 1970s, when the Public Health Act came into force, also new terminology was established. However, according to Rimpelä, the language of health policy started to change in the 1980s and consequently, in the beginning of the 21st century, several contemporary terms, such as "*kansanterveystyö*", "health centre", "health counselling", "physical", and "health education" have entirely disappeared in the national policy documents. Health promotion has replaced *kansanterveystyö*, and the only context where *kansanterveys* is present, is the Finnish name and content of the Public Health Act [*kansanterveyslaki*].

6.3 International influence and interaction

In the international health policy field, Finland has been among the most respected countries during several decades. However, the situation has slightly changed in the last 10-20 years. The socioeconomic disparities in health have increased, and especially the primary healthcare system does not function as exemplary as before. Some respondents also commented "*Finland does not know the international health field anymore*". They meant that during the war, the Rockefeller Foundation enabled university studies in the US and also later Finnish researchers and civil servants were educated mainly in the US, the UK and Sweden. Nevertheless, this kind of natural interaction has almost disappeared, largely due to the EU. However, the majority of respondents saw that Finnish international reputation in health policy is still very good, or at least fairly good. A few could not say or they did not have any opinion, but no one said that the Finnish reputation was bad.

WHO was mentioned to be absolutely the most significant influence on Finnish health policy. The relationship between Finland and WHO has traditionally been warm, close, and mutually respectful. There are long historical roots for the co-operation, and I will present some key events and persons below.

One starting point can be traced to the beginning of the 1970s. Kari Puro was appointed as the Chief of Staff in 1972 and Danish Halfdan Mahler was elected as

the new Director-General of WHO in 1973. Puro invited Mahler to Finland already in the first summer and they learned to know one another. Mahler was considered as a great visionary, and e.g. Declaration of Alma Ata and Health for All by the Year 2000 programme were launched during his term. Mahler was leading WHO almost 15 years, until 1988, and the Finnish health professionals, civil servants and Mahler shared a strong understanding of the nature of health policy and health promotion. Finland has not held important positions in WHO, but there have been many highly appreciated experts and advisers. Finland and Finnish health professionals have been regarded competent and trustworthy – the same characteristics that are often heard in general foreign policy context.

The role of Finland in WHO and in various international health networks is probably larger than is commonly understood. For instance, the Finnish Institute for Occupational Health (FIOH) has been a significant actor and partner in the WHO Collaborating Centres in Occupational Health, and FIOH is also the other permanent member in the Planning Committee (Työterveyslaitos 2012).

Finland's first term in the Executive Board of WHO was in 1975-1978, which was quite dynamic time. The main representatives of Finland were Håkan Hellberg and Kimmo Leppo, who were close to Mahler as well. Hellberg, Leppo and Puro were mentioned as the most influential Finnish health policy actors at that time, and also later. The term in Executive Board resulted in considerable number of contacts and networks, which also strengthened Finnish position.

Besides Mahler, another important person was the former Prime Minister of Norway, Gro Harlem Brundtland, who functioned as the Director-General of WHO in 1998-2003. Through Nordic cooperation, the appointment of Brundtland gave new channels of influence also to Finland.

In Europe, perhaps the most important person was Finnish Leo A Kaprio, who served as the third Regional Director in WHO Euro (1966-1985). Kaprio was a respected and highly influential public health professional. He graduated both from Johns Hopkins and Harvard, and for his distinguished service to international

health, he was elected to the Johns Hopkins Society of Scholars in 1988³. Prior to working for WHO, he functioned in several positions in the National Board of Health. Kaprio's term was very successful and he considered health policy in a wider context, not restricting to healthcare system (Kaprio 1985). Kaprio's term was exceptionally long and during his years, e.g. three major long-term programmes were organised: on CVD, mental health and environment (WHO European Regional Office 2010). Kaprio's successor, Norwegian Jo E Asvall, was in a way his disciple, so the relations between WHO Euro and Finland remained close.

Another factor affecting the cooperation between Finland and WHO was the content and reforms in Finnish health policy in the 1960s and the 1970s. Primarily due to strong social democratic actors which were referred to in Chapter 6.2, Finland had executed health policy and reforms which were parallel to WHO interests. For instance, the Public Health Act in 1972 was seen pioneering, and Finland quite naturally became a pilot country for WHO. However, the cooperation and communication was reciprocal. On the one hand, WHO supported Finland and it monitored closely what Finland was doing in health policy and health care; WHO was able to use Finland as an instructive example. On the other hand, Finnish civil servants were able to get information from and through WHO, but they also used WHO as an instrument to advance certain policies in Finland. In some cases, if there was not enough domestic support, Finnish actors "circulated" them through WHO; it was easier to get acceptance to new ideas back home with WHO support. Finland has been member in the Executive Board also in 1994-1997 (Leppo 2004). Finnish experiences of healthy public policy in 1972-1987 have been reported by Leppo and Melkas (1988).

WHO has influenced significantly Finnish public health policy programmes (Ministry of Social Affairs and Health, 1993, 2001; Sosiaali- ja terveystieteiden ministeriö, 1986) The MSAH has also commissioned two external evaluations from WHO (see previous chapter), and the reports have been partly quite critical towards Finnish system, content, and implementation of programmes. Then, one interviewee

³ <http://commprojects.jhsph.edu/sphheros/default.cfm?detail=38>

commented that it may be that these evaluations belonged partly to the "feeding process"; some civil servants may have seen these evaluations as an opportunity to send message to Finnish political decision-makers.

Be that as it may, WHO paid attention e.g. to the lack of health policy research, to the problematic division of responsibilities between the state and municipalities, to retirement of key health policy professionals and advocates and to the fact that Finnish health policy is in quite few hands and there is no new generation of health enthusiasts in sight. WHO also commented on scarce resources, both financial and human, and it questioned the authority of the MSAH; the MSAH seemed to be the central actor in health policy but it may not have a say in the operations of other ministries and institutions, not to mention municipalities. On the other hand, WHO gave positive feedback for Finnish commitment and initiatives in global health, and it also saw the Finnish EU Presidency as an excellent opportunity to advance health promotion both nationally and in the EU. The Finnish system of obligatory health education both in basic school and in upper secondary school was noticed, as well.

In recent years the role of WHO has weakened. WHO was earlier giving recommendations to the member states, but at present the marching order has been turned around. Currently, Finland's role is merely to give, as the focus is in the developing world and countries, also in Europe. On the other hand, Finnish know-how is still appreciated. For Finland, WHO is currently relevant e.g. regarding global cooperation, international trade organisations and international trade agreements regulating use and availability of pharmaceuticals.

The European Union has become a more relevant actor and the relations between WHO and the EU are very difficult. They were mentioned to have become perhaps slightly better in recent years, but all in all, they are still full of tension.

Finland has held the EU Presidency twice, in 1999 and in 2006. Every country is able to choose their Presidency theme independently, and Finland has had health in both terms. The first Presidency promoted mental health - "There is no health without mental health". This choice was questioned both at the EU level as well

as in the Ministry for Foreign Affairs, and some people were afraid of Finland being laughed at if it will be talking about "crazy people". However, apparently due to some persistent civil servants at the MSAH, Leppo (2010b) mentions Jarkko Eskola as one of them, this somewhat taboo theme was eventually chosen and it was a great success. The increase in recognition of mental health issues has continued also after the first Finnish Presidency. (Also in Eskola & Taipale 2011.)

The second Presidency promoted the concept of Health in All Policies (HiAP) and a more minor theme was the health of workers. Besides paying attention to Article 152 in TEC, HiAP was a natural continuum also to the UK Presidency "Inequalities in Health" (Leppo 2010b). HiAP was especially wished to be carried on in the health policies of other Member States also after the Finnish term. Alcohol was also on the agenda, being one of the most serious threats to public health. (E.g. EurActiv.com 2007; Ollila 2011; Ståhl, Wismar, Ollila, Lahtinen & Leppo 2006.) Although not directly connected, the new European health policy by WHO, Health 2020, does indeed contain HiAP features (Dinsdale 2011; Jakab 2011).

Also OECD was mentioned as one actor influencing Finnish health policy, or more specifically health service system and healthcare policy. At present, the MSAH has a desk officer with the Permanent Delegation of Finland to the OECD and UNESCO in Paris. Finland was also included in the recent Health at a Glance report in 2011. However, several respondents stated that Finnish Ministries commission these reports, the Ministry of Finance was mentioned in this context, and the reports were said to contain what a Ministry has asked the OECD to include in them. The manipulation mechanism was described to be similar to the earlier one mentioned above regarding WHO. One respondent said that it is quite obvious that if OECD representatives are in a country only for a week or so, it is impossible to analyse the system objectively and comprehensively in such a short time. Therefore, there is always local influence to some extent.

The Nordic Countries have been central partners, especially regarding expert and research cooperation, but the EU has weakened Nordic interaction as well. Sweden has been the principal partner, but due to the size, wealth and longer history, it has always been ahead of Finland, e.g. in research. Sweden was also mentioned

mentioned to have more extensive and active international connections. As a sidenote, I noticed that in scientific journals Sweden is often representing the health policy sector of Scandinavia or of the Nordic Countries. One interviewee confirmed that Sweden is indeed seen as the benchmark. In fact, it has happened that a scientific article covering Finland has not been accepted, but the researcher was asked to use Sweden as an example instead.

Finland has had a bilateral agreement with Scotland, and although it does not have a great significance anymore, it was mentioned to still exist. From the Finnish viewpoint, Scotland is an interesting country, because the population size is close to that of Finland, public health problems are quite similar and in general, Scotland has also been perceived as an easy cooperative partner.

Besides the Nordic Countries and Scotland, also the UK, The Netherlands, Canada, New Zealand and the US were mentioned as countries that may have had some influence on Finnish health policy. However, for instance the financing model of Finnish healthcare system is so complex and unique that there is no other country Finland could learn from. It was also mentioned, that currently parties, politicians and Ministers follow all kinds of short-term international trends and ad hoc ideas, so it is difficult to say where the influences come from. WHO used to be the most important forum and playground for the health elite, but the international field is more fragmented nowadays.

6.4 Public health research, education, and funding

The lack of public health research, specifically from viewpoints of health policy and politics of health, was worrying many respondents. They pointed out that the Finnish epidemiological, biomedical and clinical research is of top quality, and for instance, there are several diabetes and CVDs experts who are at the top level also globally.

However, as this tradition of epidemiology and medical research has been so strong, there have not been many initiatives for health policy research and for

some reason, the lack of health policy experts has not been seen as a problem among decision-makers, either. It may be that due to lack of information and research, there is also unawareness of what should be investigated or what kind of information could be available to support decision making.

Also, regarding health services research, during 2004-2009 the number of studies has been relatively low compared with e.g. other Nordic Countries. (HSR-EUROPE 2011.)

Some informants mentioned that in the 1970s and the 1980, there were many provincial doctors and civil servants working in the National Board of Health who were sent to several universities abroad to study health policy and learn from other systems and political environments. The exchange programmes usually lasted for a year. Finland had this kind of contract at least with the world-renowned London School of Hygiene and Tropical Medicine, University of Leeds and University of Edinburgh.

There are five Faculties of Medicine in Finland, located in Helsinki, Kuopio, Tampere, Turku, and Oulu. They have public health institutes or they offer some public health courses, but they focus e.g. on NCDs, social epidemiology or healthcare research; health policy per se is investigated nowhere. Also nursing science is offered in some universities.

The only universities offering some kind of health policy related education are in Tampere, in Kuopio (University of Eastern Finland), and in Oulu.

In Tampere, the School of Health Sciences offer public health degrees, also a Social and Healthcare Management eMBA-program, but they are mainly focusing either on health sciences or on healthcare systems, especially management and leadership. In Kuopio, the Department of Health and Social Management which functions under the Faculty of Social Sciences and Business Studies, offers studies such as Social Management Sciences, Health Economics or Health and Human Services Informatics. In Oulu, the Faculty of Medicine offers Degree Programme in Health Management Science, but the focus is also in management, planning and development. Hence, these universities do not directly offer health policy

studies, postgraduate or post-doctoral degrees, or health policy research, either. In general, there is some academic research made e.g. in sociology, social policy, medical anthropology, art history and similar subjects, which have some connection to health, social determinants of health and healthcare systems, but the number is anyway relatively small.

The MSAH noted the situation in the mid-term evaluation of Health 2015, as well (Sosiaali- ja terveystieteiden ministeriön ja Terveystieteiden ja hyvinvoinnin laitoksen asiantuntijatyöryhmä & Kansanterveyden neuvottelukunta 2012, Chapter 8.5).

To present the Finnish situation in international context, Buse et al. (2005, p. 1) summarise: "[these] political dimensions of the health policy process are rarely taught in schools of medicine or public health".

Some respondents said quite bluntly that in their opinion, health policy expertise does not exist anywhere at the moment, but some others mentioned that there are some experts with the MSAH, even more with THL, and in the Universities of Tampere and Eastern Finland, professors Juhani Lehto (Tampere) and Juha Kinnunen (Kuopio) were mentioned.

For an independent researcher or a postgraduate student, finding a research group or supervisor may be challenging. Also finding funding opportunities for health policy research may be problematic. There is one multidisciplinary Doctoral Programme in Public Health (DPPH) which involves the Universities of Eastern Finland, Helsinki, Oulu, and Tampere, THL, the Finnish Cancer Registry, and the UKK Institute.

The Academy of Finland has offered some health-related programmes, such as Health Service Research, TERTTU (in 2004-2007), Health Promotion Research Programme, TERVE (in 2001-2004) and Responding to Public Health Challenges, SALVE (2009-2012)⁴, but as can be concluded by their names, they have not been health policy research programmes, either. Sitra, The Finnish Innovation Fund, runs some wellbeing projects, but their focus is e.g. in future innovations, busi-

⁴ <http://www.aka.fi/en-GB/A/Programmes-and-Cooperation/Research-programmes/>

ness, sustainable development and leadership. Finpro, an organisation for promoting Finnish companies' and building their international growth and success, has also had one joint project with the EU, "Prevention and care of chronic diseases associated with lifestyle," but its aim was to advance both political and commercial EU presence in Thailand and Malaysia. All in all, at the moment the most likely option is trying to get funding from a couple of private foundations, but without a research project, supervisor, or doctoral programme, receiving funding is practically impossible.

The state has cut research funding and the future does not necessarily look any brighter. The MSAH does not execute own academic research as their research institution is THL. The Division of Welfare and Health Policies in THL is quite small already and based on my interviews I would say that its position is definitely not secured if the prospective performance agreement of the MSAH and THL does not take this into account.

Regarding funding, it is difficult to say which came first, the chicken or the egg. It may be that there is no research because there is no funding, but it may be as well that there is no funding, and indirectly research, because there are no good applications. Anyway, receiving funding for medical and epidemiological health research is significantly easier, in terms of funding sources, research projects, tradition, and supervisors, than when trying to find funding for health policy research which does not quite belong to anywhere in the academia at the moment.

7. ACTORS IN FINNISH HEALTH POLICY

The classification of actors is based both on my research and categories drawn from literature, especially Buse, Mays, and Walt (2005) and Mattila (2000, C. 3.3). The actor groups defined in international literature, especially emphasis on certain actors, is not always applicable in Finnish politics and policy making. For instance, the geographical area of public health policy literature often cover the US, the UK, Australia or Canada, or on the other hand the developing world. Due to the history and development of the Finnish democracy and society, corporatist and nongovernmental organisations are in a greater role than in many other countries. On the other hand, mass media and industry have not been as significant actors as perhaps elsewhere, at least not yet. The theoretical framework for this chapter can be found in Section 2.2.2 and in Chapter 3.

7.1 Ministry of Social Affairs and Health

As was mentioned in the historical overview in Chapter 6.2, the MSAH was established in 1968 when health affairs were transferred to the Ministry of Social Affairs. Labour affairs were also included in the remit until 1989. After the World War II, the role, responsibilities and budget of Ministry of Social Affairs and later the MSAH have gradually grown and strengthened. Historically, the MSAH has shown example in the central government sector in decentralization of authority to local institutions, provinces and municipalities. Concurrently with the reform in 1968, a department for research was established with the MSAH to produce scientific evidence and data to support decision making. However, the role of the MSAH did not become very strong in research, and the National Board of Health, National Board of Social Welfare, National Health Laboratory and National Medicine Laboratory were operating in their respective areas. Kari Puro's appointment for the Chief of Staff was a major change in the contemporary greyish image of a civil servant, as he was young, politically committed and he also came from outside the administrative system. As an interesting grace note, it is worth mentioning that Puro is said to have been discovered by the aforementioned Pekka Kuusi. (Suonoja 1992, p. 493-497; p. 697.)

Around the time of Puro's appointment also other young, enthusiastic and promising civil servants and researchers entered MSAH. Many of them were close to the Social Democratic Party and held a degree both in medicine and social sciences. These men and their peers in national research institutions eventually became the *crème de la crème* of Finnish health policy for decades to come.

The National Board of Health, which was administered by the MSAH, was in many ways the center of attention and action. It was responsible for coordination, supervision and development of health and medical care, pharmacies, and manufacturing and sale of pharmaceuticals. It was also responsible for coordination and supervision of the operations and budgets of hospitals and laboratories, and carried out applicable research, consultation, counselling, planning, rationalisation and standardisation. The National Board of Health functioned both as an expert on health care and as a planning and coordination unit. (Suonoja 1992, p. 623.) The Board was very influential and for instance, all the open positions either in the public hospitals or health centres had to be approved by the Board before filling.

However, in 1991 the National Board of Health and the National Board on Social Welfare were merged after an intricate process, and the National Agency for Welfare and Health was born. Surprisingly only after one year, in 1992, there was again an organizational reform and the National Agency for Welfare and Health was abolished and the National Research and Development Centre for Social Welfare and Health (Stakes) was created as a replacement.

The organisational changes did affect also the MSAH, because the incorporation of the National Board of Health restructured the Ministry as well, both in terms of organisational structure and personnel. In general, the reform strengthened the role of the MSAH. The Chief of Staff Kari Puro changed jobs in 1990, and his successor came from the National Coalition Party. Among other nominations were e.g. Heads of Department Kimmo Leppo, Jarkko Eskola, and Markku Lehto. Besides the Chief of Staff, almost all the other posts were politically influenced as well: the new Director of the National Board of Welfare and Health (Vappu Taipale, SDP), the Head of Social and Health Services Department (Leppo, SDP), the

Head of Preventive Social and Health Policy Department (Eskola, SDP). Assistant Heads of Departments were divided as follows: SDP 1, Centre Party 1, Swedish People's Party of Finland 1, National Coalition Party 1, independent 1. (Suonoja 1992, p. 631-2.)

Profound administrative changes have been executed in the 1990s and 2000s as well. The departments but also research, supervisory and development units have been reorganised and renamed. The ongoing change has caused tension; the arguments for and against reforms have been both political and/or practical, and the parties involved, both political as acting, have not always agreed on the need or the way the reforms have been carried out. Especially the merger of the Research and Development Centre for Social Welfare and Health (Stakes) and the National Public Health Institute (KTL) in 2009 has raised strong criticism.

At the moment, the MSAH administers three sector research and development units: the National Institute for Health and Welfare (THL), the Finnish Institute of Occupational Health (TTL) and the Radiation and Nuclear Safety Authority Finland (STUK). It also administers Valvira, the National Supervisory Authority for Welfare and Health, which guides municipalities and Regional State Administrative Agencies on legislation associated with Valvira's jurisdiction and supervises implementation and conformity to law in different fields of healthcare and welfare. These institutes will be discussed in the following chapter.

As the domain of social, welfare and health is in many ways fundamental, during the decades, the MSAH has been in the centre of all kind of controversy and influence. Especially the inception of new Tobacco Act (693/1976) in 1977 represented new health policy and new kind of state intervention in the production, marketing and consumption of unhealthy commodities. Also regarding alcohol policy, the MSAH has been, and still continues to be, in the middle of severe lobbying and sometimes almost a battle of industry, economy, NGOs, health and medicine.

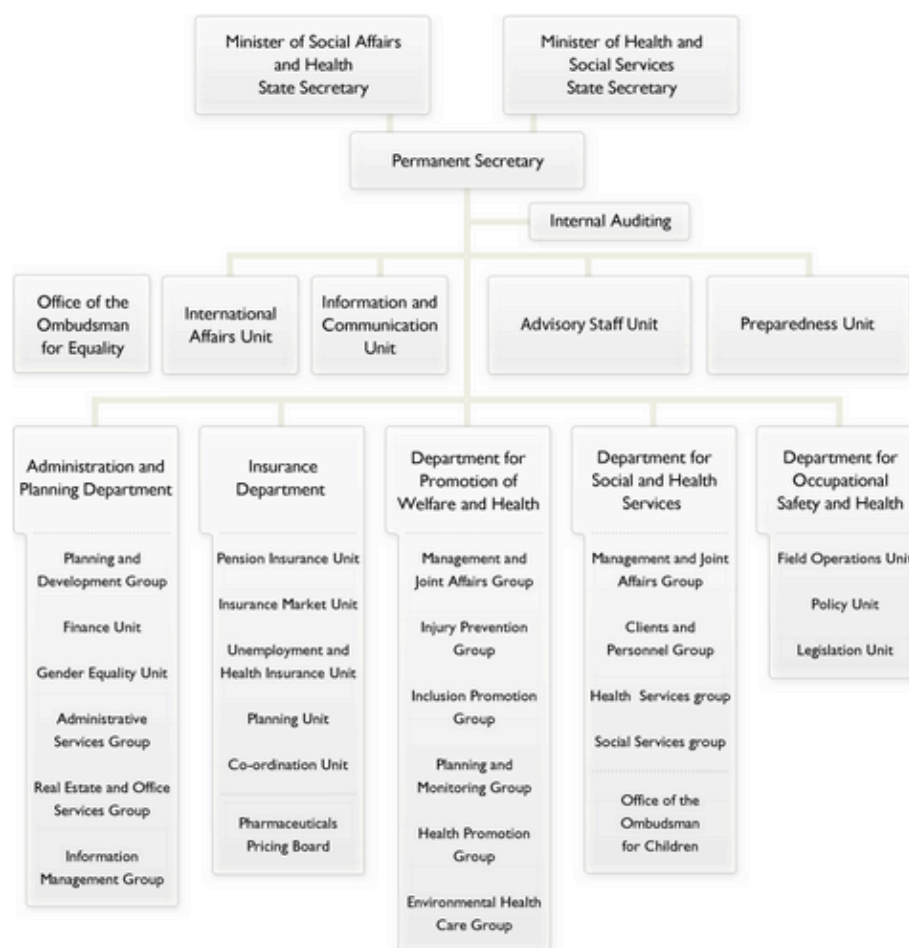


FIGURE 3. The administrative structure of Ministry of Social Affairs and Health (10.11.2010)⁵

The interviewees saw the role of the MSAH as multifaceted. On the one hand, the ministry was described as a central actor, institution, the MSAH Corporation and a political decision maker. The MSAH was seen responsible for “everything that has a health aspect”. One respondent formulated the role saying that the MSAH is very hard to disregard: the ministry is not necessarily the initiator or even an active advocator but if the MSAH opposes a motion or an initiative, it will not pass.

Many respondents brought forth the complex relationship between the MSAH and the sector research institutes, especially THL. The position of THL as a quite autonomous unit was recognised, but some respondents felt that there should be

⁵ <http://www.stm.fi/en/contact/departments>

more research in the “core” MSAH as well because the ministry was seen at the moment to depend quite heavily on THL. I will get back to this in Chapter 7.2.

Almost everyone mentioned that the position of the MSAH is very challenging with respect to the Ministry of Finance (MF), and increasingly also with the Ministry of Employment and the Economy (MEE). Especially the MF, being responsible for the state budget, was seen as a very tough opponent. However, also the MEE was seen to have entered the domain of the MSAH and several interviewees mentioned that the interests of the MEE and the MSAH are not always equal. Nevertheless, one respondent commented that in principle, regarding the resources available already for the MSAH, it should be able to execute at least some structural and administrative reforms that might help to solve some of the problems that Finnish health policy is currently facing.

Sports policy in Finland is administered under Ministry of Education and Culture. Referring to his experiences, former Minister for Health and Social Services and present Member of Parliament Osmo Soininvaara commented (Suomen Liikunta ja Urheilu 2002) the challenging collaboration between the MSAH and the Ministry of Education and Culture by saying that

“The administrative boundaries [between ministries] are extremely important, and because health promoting physical activity is located in between, advancing it is difficult. Kirkkokatu [a street where some ministerial buildings were located in Helsinki] is the broadest street in Finland – crossing is impossible.”

With respect to international affairs, especially the EU, also Ministry for Foreign Affairs (MFA) was seen partly contradictory. Finland, led by the MFA, was called an exemplary EU student and following the rules stricter than any other country in the EU. The respondents saw that since the 1990s, the influence of the European Community, later the EU, has gradually grown also in the health sector, although it formally belongs to the national competence. Several persons commented that

they feel slightly powerless and it is hard to follow the current EU legislation and especially to try to estimate if it has some influence on health. The lack of EU-related health policy research was also mentioned.

In relation to EU-matters, also the current demand for EU coordination in WHO meetings emerged (see Chapter 5.6) and many respondents found it astonishing. They argued that the functions of the EU and the WHO are totally different and from health perspective, it is disastrous if the values and priorities of the EU will cover also WHO. When asked, only few respondents had some impression on why this change has happened, although many of them had been following this procedure - it had just been taken as given and because "the Ministry for Foreign Affairs just informed us about it". The Lisbon treaty was given as a general explanation but no one had a very clear idea on the details.

In general, the Finnish EU membership in 1995 was seen to have profoundly changed the operations of the MSAH. Some departments were said to have been forced to carry quite heavy responsibility although the MSAH did not get extra resources, and suddenly the civil servants had to participate in dozens of divisions and meetings and some officials spent more time abroad than in Finland. There were not that many internationally oriented civil servants or ministers who would have had the required skills, e.g. in foreign languages. Some interviewees commented that they feel that the Ministry for Foreign Affairs, or the Government as a whole may not have understood, or still do not understand, how much the workload of the MSAH increased due to the membership. The time was not favourable for increase in resources, due to the recession of the 1990s, but still the old responsibilities had to be covered.

The Ministry of Agriculture and Forestry (MAF) was also mentioned, mainly due to the relation between agricultural policy and nutrition. The MAF administers the National Nutrition Council, which is an expert body issuing nutritional recommendations. Although nutritional recommendations are indeed very central in terms of public health, the MAF and the National Nutrition Council were in a

quite minor role in my study. In terms of lobbying and food industry, almost all respondents believed that the MAF is the focus of pressure.

One respondent described the role of the MSAH as follows:

“(--) I believe that the role of the Ministry of Education and Culture is bigger in education policy than the role of the MSAH is in health policy. On the other hand, the role of the MSAH is bigger in health policy than the role of the MSAH is in retirement policy. (--)” CS2

Nevertheless, although the MSAH has very often been seen to be alone in promoting and defending health against other ministries and authorities, some respondents wanted to emphasise that in the last ten years there has also been positive development in the cooperation. One respondent saw the Finnish Advisory Board for Public Health as a good forum for exchanging information on current legislative projects and also for finding common themes.

The controversy was not limited to the external relations but also internal organisation. The MSAH is divided institutionally and it accommodates two Ministers. However, this division was regarded sometimes as problematic. During the past decades, the Ministers have had very different profiles and stakeholders, and their respective departments have not necessarily collaborated much, which has internally caused problems in communication and cooperation. Personal relationships were also mentioned, both in positive and negative context.

Although the research of Jaakko Nousiainen (1992) is already twenty years old, based on my study, his results are still valid. He describes (ibid., p. 80-120) strikingly well the role of a minister as a Head of Ministry, the relationship between Ministers and civil servants, and the tight schedule and enormous workload which Ministers meet. My study revealed as well that the focus has switched between political and administrative leadership, also depending on the Minister. An important factor is, regarding the power of civil servants, that Ministers very rarely have time to think what they need to know or what kind of motions or projects his/her subordinates may be working with, let alone to have time to do something

about it. Ministers know more or less only those things that they are told, which probably also affected my case, the process of Health 2015.

Nousiainen (1992, 80-1) writes that the Ministry of Defence and the MSAH tend to be among the least wanted ministries. Nousiainen called, based on his classification, these respective ministers “parliamentary amateurs”, as almost half of the ministers with these two ministries belonged to this class. With respect to the MSAH, Nousiainen writes that although social sector uses lot of resources, changes the society and deeply affects the lives of citizens, it has not been appreciated in a male dominant political culture and the leading posts have not been considered as attractive. In many Finnish governments, both MSAH portfolios are usually given to women. Nousiainen adds that if the portfolios for Minister for Foreign Affairs or the First Minister of Finance are on the top of the unofficial ranking list, the Second Minister of Social Affairs is at the bottom.

This was confirmed also in my research. Two respondents described ministerial appointments as follows:

"(--) For instance, at present, when the ministers are appointed and now that we have had four-year ministers actually from the beginning of the 1980s, since the President Koivisto's term, it has been almost... This Second Minister, so called Minister Responsible for Services... It has not ranked very high among ministerial appointments, it has always been someone, who has been a little bit... just take someone young (--) a bean bag, it has never been very strong...(--)" CS4

"(--) Then, in the beginning of the 1970s, the ministers (--) and I don't mean to speak ill of anyone, they could be good ministers per se, but they were anyway such ministers that when the parties were sharing the portfolios, at first they shared this and that, the most important ones, which needed the strongest expertise and then the MSAH was in a such position, that when there was a need to find someone whose regional, gender and language attributes were somehow balanced, that person was appointed with the MSAH. It meant

that this person was not perhaps the most influential person in the respective party, which of course could be noticed also in the authority...(--)" CS2

Two ministers received positive feedback in several interviews, Paula Risikko (the National Coalition Party) and Eeva Kuuskoski (Center Party). Minister of Social Affairs and Health Paula Risikko is holding office in the current Jyrki Katainen's Government and she also functioned as a Minister of Health and Social Services in Vanhanen II and Kiviniemi Governments in 2007-2011. Eeva Kuuskoski was the Minister of Social Affairs and Health in 1983–1987 and in 1991–1992.

Minister Risikko's competence was described for instance:

"(--) Of our current ministers, Minister Risikko knows the subject extremely well, as well as anyone can ever know it, and better than most of the experts. (--)" R4

Eeva Kuuskoski's passion was appreciated as well:

"(--) Well, as I said already in the beginning (--) in Finland, health policy has mostly been led by civil servants, there have been a few ministers during the years who have full-hearted delved into the matters, Eeva Kuuskoski was one of them, and someone else as well, but...(--)" CS3

Minister Risikko is a Doctor of Science (Health Care) and Kuuskoski is a pediatrician. This actually fits quite well with a more general notion of my study.

First of all, majority of my interviewees are medical doctors and some of them also hold another degree in social sciences. Indeed, it was commented that in Finnish health policy it is practically impossible to hold any higher post if one is not a medical doctor; it was said to have been an unwritten rule. The historical basis was seen to stem from the 1970s and the 1980s when most, if not all, of the most influential persons happened to have at least one, if not two degrees, and

the medical profession has been highly appreciated in health policy. Some ministerial tasks also require medical or pharmaceutical knowledge, so it is only natural that health professions, such as medical doctors, nurses, and pharmacists are represented among civil servants. Also the abolition of the National Board of Health brought physicians into the MSAH. One respondent commented that for the Finnish Medical Association and their prospects, it has been a lottery win that the MSAH is full of medical doctors.

It is worth noticing, however, that almost all the interviewees who brought up their background education and possible clinical experience usually added that he/she is not a member of the FMA and consider him/herself more as an advocate for the population and public health than for physicians.

Nevertheless, many interviewees also commented that it would be good to have also other professions involved, and in general neither medical doctor degrees nor nursing degrees include health policy studies. Therefore, there is no reason why a degree in social sciences or some other relevant discipline would not qualify, as they may include more elements of administrative or policy studies. After all, the expertise is achieved through work experience.

The role of education appeared also in another context, when discussing the position of health policy among other societal policies. One respondent was pondering that in current Finnish politics, quite few politicians have social policy background and their interests lie elsewhere. Therefore, there is understanding for health matters but only to certain extent, and if the interests of the industry and public health are on opposite sides, public health often loses. Bargaining is difficult because very often the interests of the industry are clear, so are the disadvantages, and e.g. some reform may affect only certain companies or businesses which may start campaigning against the reform. The health benefits, on the other hand, are far away and they may affect “unknown citizens”. Therefore, the facets are not equal.

Different professions and educational backgrounds affect also the language which is used. When THL was created, there was a lively discussion whether the name

should be “Institute of Health and Welfare” or “Institute of Welfare and Health”. The difference seems quite small but apparently it matters. One interviewee commented that if something in health policy is called “welfare”, it sounds too abstract or perhaps even too much of social policy and the “health people” are not interested or understand that the matter would concern them as well.

The relationship between ministers and civil servants appeared in many contexts. Although health policy was described being largely led by civil servants, the common understanding was that it still matters which parties are in the Government and who the Minister is. Several respondents wanted to emphasise that “the Minister is the king or queen” and officials do what the Minister wants. Party political changes in previous Governments were seen to have caused bouncing in the course of conduct and in administration, as Ministers may have wanted to leave their mark in history.

Preparation processes of the MSAH were considered to be very technocratic and to be based on the opinions of experts and civil servants. Few respondents mentioned, however, that they feel that from their or their organisation’s viewpoint the MSAH has lately changed; the preparatory process was experienced to be more open than before, which was appreciated. Some respondents said that political planning was not very popular at some point and the administration wanted to dispose the political committees (cf. Chapter 4) and replace them with “neutral decision makers”, referring to experts, civil servants and other professionals. On the other hand, one interviewee told about a campaign “a civil servant eats also at your table” and commented to have experienced a real hatred towards civil servants for some decades ago. It was mentioned that it might have been one reason why the National Agency for Welfare and Health was transformed into a research institute. Thus, it seems that the negative attitude towards both civil servants and politicians is a quite permanent phenomenon.

Regarding the substance, many respondents felt that the main challenge for the MSAH is the societal nature of health policy – Health in All Policies. On the other hand, it is good to have expertise in one Ministry and research units, but as the MSAH do not pursue authority over other Ministries and there would be no point

for the MSAH to allocate its own resources to other Ministries, the respondents reasoned that health policy cannot be pursued in the best possible way. A couple of respondents mentioned the Government's Policy Programme for Health Promotion (2007-2011) which was administered in the MSAH and they stated that in their opinion, it should have been located directly under the Prime Minister's Office. In regard to the Finnish Advisory Board for Public Health, several informants made similar remarks.

Last three themes to emerge were the relationship with the municipals, the amount of health policy knowledge and the role of the MSAH between different stakeholders.

All respondents commented in one way or another that the state subsidy reform in 1993 was the turning point. Some informants commented that although they favoured the administrative reform because they thought that the authority of the National Board of Health was a "bit too much" and there must be expertise and wisdom at the local administrative as well, seeing the situation now have made them think if we have reached the other extremity. When discussing the state authority over municipalities, the most common ministerial argument usually is that "there is nothing we can do". However, several persons mentioned that referring to e.g. so called care guarantee, the MSAH would have the option of sanctioning municipalities if they do not obey the law also regarding primary healthcare.

One person commented, before explaining that the main point in making the law was to try to balance the great difference between primary and secondary healthcare,

"(--) This is a crucial question and still (--) all these recent law amendments... although the legislation on time frames for appropriate care were defined both for primary and hospital care, only the latter was properly monitored and sanctioned. Here, again, no one cares about health centres, I think it's unbelievable (--)" CS3

Another interviewee pointed out that in fact, the monitoring authority is Valvira but in his opinion, the MSAH could indeed fine the municipalities. He was wondering if the current Minister is too weak to use all the “weapons” that exist, or if no one knows that they exist, or if there are some political obstacles which prevent the Minister.

One important aspect, which appeared frequently, was the lack of Finnish health policy research and the change of generation. I was especially interested in this viewpoint because based on literature and discussions, I have named the Huey, Dewey, and Louie of Finnish Health Policy, in power since the 1970s, namely (in alphabetic order) Jarkko Eskola, Kimmo Leppo, and Tapani Melkas. There are other significant persons as well which appeared in my interviews, such as Jussi Huttunen (KTL). Nonetheless, e.g. Leppo, Eskola, Melkas, Huttunen, and former Chief of Staff Markku Lehto have already retired, also the Director General of THL Pekka Puska will retire in a few years. I was interested in knowing if there already is or will be a new generation of health policy-makers and opinion leaders but I did not receive many names. My informants assured that there are still some great and competent professionals in the MSAH and in sector research institutes, especially THL, but not particularly many.

Several persons mentioned that they have been worried about the situation for some time already, as so much “silent information” and contacts have disappeared with the retired civil servants and they are unsure if there will be the kind of continuum of Finnish health policy that there has been in the past. However, one person commented that political and global health policy reality and arena is nowadays very different from before and new people make new contacts. Another one emphasised that despite visible and strong personalities of the past, there were also other important people involved and these “personifications of Finnish health policy” were not the only ones operating in the domain.

7.2 The National Institute for Health and Welfare and other sector research institutes

State-owned sector research institutes function under Ministries and their financing comes from the state budget. The state and the institutes sign a performance

agreement which does not cover details, such as individual research topics, but it determines and defines the main framework for operations. From three institutes, that the MSAH administers, THL appeared the most relevant in my research. The Finnish Institute of Occupational Health (TTL) and the Radiation and Nuclear Safety Authority Finland (STUK) were just briefly mentioned: STUK did not play any role and TTL was mentioned to be the most independent one and embodying a lot of expertise. One respondent told about rumours that TTL would be merged to THL but others were rather emphasising the independent role, speciality and expert knowledge of TTL.

The National Institute for Health and Welfare begun its operations on January 1, 2009, so it is a quite young organisation and still developing. The new institution was merged from the National Public Health Institute (KTL) and the National Research and Development Centre for Social Welfare and Health (Stakes) and as I have written already earlier, views on the arguments and justification behind the merger differ quite strongly.

In 2008, the contemporary Minister of Health and Social Services Paula Risikko stated that the MSAH wants to clarify the roles of fundamental research and sector research. She said that at the same time when the fundamental research will be transferred to the universities, sector research will mainly remain applied and it will be a resource for political decision making and support the implementation of societal policy. (STM 2008)

The Act on the National Institute for Health and Welfare (668/2008, section 1) defines the purpose of THL as follows:

"The purpose of the National Institute for Health and Welfare is to promote health and welfare, prevent diseases and social problems, and to develop social welfare and health care activities and services. The Institute is subordinated to the Ministry of Social Affairs and Health."

This statement includes many issues and concerns that I met during my research process.

First, there was a general agreement on the influence of THL and it was described as follows:

- “expert organisation”
- “a significant resource, also internationally”
- “powerful”
- “influences the policy agenda”
- “sets the objectives for Finnish health policy, a task which used to belong to the National Board of Health”

However, when asked about the organisation of THL or how the cooperation between the MSAH and THL works, the respondents were not as like-minded or positive.

Most of them criticised the merger in one way or another, either because of the process or how THL is organised. In many comments, the merger was described as “it was a purely political act, some parties needed to be removed from power” and it was mentioned to reflect the current reality of political appointments. One person said that in his opinion, one objective was to reduce workforce in public sector. On the other hand, some persons did not want to comment or they did not know about the potential political aspect but instead they emphasized the overlapping roles of KTL and Stakes and found the new arrangement practical and important; now both organisations are under the same roof. However, some of these interviewees expressed their dissatisfaction with how THL is organised and mentioned that they would have wanted to see more extensive and genuine re-organisation of departments and units.

Most of the respondents explained that the merger of KTL and Stakes was a kind of “clash of civilisations”. KTL was a biomedicine-oriented, highly respected research institute full of medical doctors. Stakes, on the other hand, executed research in social sciences and humanities, with only a small amount of research which could be categorised as epidemiological. Some respondents mentioned

that although KTL also did some policy-relevant research, such as epidemiology of common NCDs and environmental health, of these two Stakes pursued the most policy relevant research from the viewpoint of the MSAH. Regarding the size of organisations, KTL was larger than STAKES and the reform was seen as “the giant ate the dwarf” or, to put it in medical terms: phagocytosis. Hence, the rules and code of conduct of THL were largely seen to be transferred from KTL.

Regarding the merger, many respondents articulated their concern for the diminished role of social policy research and social research in general. A few persons mentioned that the MSAH has indeed tried to increase the amount of health policy research, especially critical policy analysis, already when there were KTL and Stakes, as well as in the era of THL, but “for some reason, they have not been very interested” (CS6, CS5).

Regarding professions and health policy, one respondent commented that:

"(--) Medical doctors, who have never quite understood or appreciated politics or practical health policy making, are mentally quite distant from the MSAH (--)" R7

Professions and the controversy between health and social policy were also mentioned e.g. as follows:

"(--) What has been done after the merger, it has gone exactly the way that at least I said immediately when I hear about this [the merger]; it will mean a significant rundown in the social policy department in THL, the biomedical paradigm will always win social sciences if they are like this. It is again about the appreciation of a [medical] profession, and that has exactly happened, too many good guys have left because they don't feel at home anymore...but still, it is an extremely strong institution that does plenty of good work. (--)" CS3

"(--) In my opinion, social policy lost, and it was clear right after the appointment of Puska for the General Director, he has very strong

own preferences which are chronic diseases and disease prevention. He doesn't... Those fields are in his interest, so we knew that it will happen and that has indeed happened, social policy is in a quite weak position (--) CS5

Despite criticism, it was also mentioned that the new THL is much larger than the two previous institutions and this kind of reform always solidifies an organisation. It takes time before the organisation and staff adapt to the new situation. THL has a quite broad list of statutory duties, and the staff and the research interests of the previous organisations are constantly contending for resources.

All this consistent with my observation that the boundary between research belonging to academic institutions and on the other hand, the policy relevant sector research seems not to be totally clear. Some informants mentioned that especially during the years of KTL, some research, such as molecular genetics, was already transferred to University of Helsinki, but there is still some research left which in their opinion is not policy-relevant and should be done elsewhere. However, they did not specify the topics.

The resources are scarce, and while some persons commented that THL should just use and direct its assets in another way, some informants stated that THL has not much leeway and too much steering from the MSAH can narrow the focus of THL even more. It was mentioned that the common attitude is "THL will take care of this and that" and every time there is a new piece of project or legislation, THL will probably be involved, but it will usually not get more resources or time to cover even the previous tasks. Especially the municipal cooperation and different development projects are usually channelled through THL. Current operational experiences of THL were called as "fire extinguishing", meaning reactivity instead of proactivity.

In many comments, the respondents wanted to emphasise the unique role of THL and TTL. They said that especially considering the size and population of Finland, the Governments elsewhere can only dream about this kind of research resource supporting Government and policy making. They were sure that if the resource,

work of over a thousand experts, is used wisely, there is potential to solve Finnish health policy problems. One respondent commented that Finland should take better advantage of this rare opportunity among the other EU countries and sell some services or innovations for them, too.

When asked about the freedom of research and opportunities for societal criticism, the most common answer was that the research is not as free as e.g. in universities and other academic institutions because sector research institutes are not totally autonomous. There are always strings attached.

However, no one said that there is censorship or other prohibitions concerning e.g. research topics, but it was mentioned that there is a difference between the opinion of an individual researcher and the official stance of an institute, such as TTL or THL. There have apparently been some cases and output that have received irritated feedback from the MSAH, but it was said not to be very common. It was also mentioned that researchers may have different “roles” e.g. some persons, their behaviour, or networks have been and may be tolerated better than some others’.

Finally, I was interested in how my informants saw the cooperation between the MSAH and THL. The opinions varied, but the variables were not divided e.g. by axis 'civil servant' - 'other' or 'retired' - 'still working'. Therefore, it was not possible to form any grouping because many respondents' position was “in principle, it works fine, but...” and eventually the replies could have legitimately been classified in both categories ‘works well’ ‘does not work well’. The most common argument was that in principle, this kind of structure where the MSAH and an independent sector research institute have a performance agreement works fine. Then, several respondents commented that “but in reality, it does not work” or “but they [sector research institutes] do whatever they wish”. Those, who found the cooperation to work fine, appreciated the autonomy and the separate roles of the MSAH and THL.

Some respondents summarised the difference in saying that THL is an expert organisation which recommends needed actions, but the role of the MSAH and

politicians in general is to make decisions. It is the responsibility of political decision-makers to decide how much they will listen to scientific evidence on health effects and how much other stakeholders and interests are at play.

“(--) THL on the other hand is, or it should be, free from those political interests and views which different political parties have on how the services should be arranged or what we [Finland, health professionals] should concentrate on, but it has an expert role (--) it should, based on that role, align the future and crucial future challenges and actions, be an active operator, and not only when the MSAH asks; THL executes a great amount of reports and tasks demanded by the MSAH, but that’s the other function which THL has. (--)” R8

THL has recently published its strategy for 2011-2020 (THL 2011). The political and societal influencing was mentioned to happen at several levels and contexts, and e.g. the target groups of communication are divided in two: the mass media and citizens, and political decision-makers.

7.3 Municipalities

A municipality is a basic regional administrative unit and a basic unit of the self-government of the citizens in Finland. Currently in 2012, there are 336 municipalities. Finnish municipalities are very influential and in the European context, Finnish municipalities have a very extensive remit. Compared with the share of the state in service production, the municipalities cover c. 2/3 of the public services, the state being responsible for c. 1/3. Social welfare and health care is the largest local government function. The municipalities may decide how the services are produced: either by the municipality itself or they can be bought from a private health care operator or being coproduced. Due to autonomy and strong authority, municipalities are in the focus of health and welfare promotion. Besides healthcare, municipalities can influence the health of the citizens through other policies, such as environment, community planning, transportation, housing, employment, education and sports. There are also several laws that oblige munici-

palities, such as the Finnish Local Government Act, Public Health Act and Health Care Act, among others⁶.

The municipalities belong to several joint authorities [kuntayhtymä], which can be statutory or voluntary. At the moment, there are three statutory joint authorities: twenty healthcare/hospital districts [sairaanhoitopiiri], sixteen special care districts and eighteen regional councils. Healthcare districts are responsible for organising the secondary health care, and the tertiary level of Finnish healthcare consists of five university hospitals in Helsinki, Tampere, Turku, Kuopio, and Oulu.

As I mentioned in Chapter 6, the main problem at the moment, regarding municipalities in Finnish health policy, is the imbalance between primary and secondary care. The citizens need to queue for weeks, even months, to be able to have an appointment with a GP or a nurse, which means that patients either use private services that are usually quite expensive or if they cannot afford it, they do not get treatment at all. Occupational health care covers the employed part of the population but unemployed, pensioners and other groups outside working life depend on public health care.

“(--) The situation of medical doctors in health centres and hospitals is absolutely terrible (--) no wonder that doctors working in health centres are in the forefront fighting with increasingly aging population with multiple disorders in such working environment, without the support from the colleagues, which would be available in hospitals. On the other hand, it’s possible that doctors are leaving for the private sector and rather to the occupational health, which has totally gone on sidetrack, very few have enough strength to stay... Well, I’m sure that one cannot do anything else than to change legislation, that there would be steering instruments, and... It’s not impossible of course, they have been changed once already in that way (--) The reasoning was that all wisdom lies in the municipalities, well, the Fin-

⁶ http://www.stm.fi/en/social_and_health_services/legislation

nish municipalities are bloody small units that there is not enough wisdom and the classic question, that if the power is transferred to municipalities, to whom is the power transferred? In healthcare sector it is the professions and which professions are the strongest? They are the specialists in hospitals. I think it's excellent that hospitals are in such good shape, as they are, but I think it's very bad that...primary care is broken. (--) I don't miss the old-fashioned, very detailed regulation, which we had in the 1970s and partly also in the 1980s, because that was the time when it was time to use, in a way harder steering instruments because it was a significant system reform, and when it's been done, one can very well loosen reins, but these kinds of strategic matters..., like, well right now, allocation of human resources and other things like that... Just think about it, if in education sector one executed that kind of shift in balance that when we talk about basic education and polytechnics and universities, so, well, if suddenly some reforms were made, which would lead, in a way or another, to a situation, where all the money would go to universities and not to basic education...this is analogical and well...it wouldn't work." (--) CS3

The municipalities are at the moment in the middle of a major turmoil. The Government is preparing a nationwide reform in local government structures, leading Ministry being the Ministry of Finance. The social and health sector and service structures have been outlined in a working group on service structure that has operated under the MSAH. The working group gave its interim report in June (STM 2012). The working group on service structure presented three alternative suggestions for how the service production could be organised, and the Ministerial Working Group on Social and Health Policy chose one of them to be developed further. The schedule and next steps are not available as I am writing this, but e.g. THL has wished for a rapid process, so that the future structure for Finnish

social and health care can be aligned and concretised already during the upcoming autumn.⁷

All respondents agreed that the relationship between the state and municipalities is complex and problematic. The single most mentioned reason, a starting point, for the somewhat inflamed situation was the state subsidy reform in 1993.

“(--) Then, since 1993 we haven’t had national health policy anymore, we only have municipal health policy and (--) we have 400 [sic] actors. (--)” R1

Many respondents commented that some kind of reform is needed, but there were several opinions on how the reform should be executed. The general understanding was that there are too many municipalities in Finland, especially too many that are too small in terms of healthcare and social services. Municipalities also differ in their skills and capacity to negotiate with multinational service providers. One respondent commented, however, that the size of a municipality or so called population base is not the only thing that matters; for instance the city of Espoo is large enough, but still no one knows why the healthcare sector does not work. Therefore, research is needed also from structural, management and leadership viewpoints.

The reform in 1993 totally changed the balance and division of work between the state and municipalities. Most respondents saw that there are not many instruments that the state can use; legislation and sanctions were usually mentioned. However, they were considered as quite heavy and also bureaucratic means.

“(--) I remember well the discussions in the mid-1990s when I and our lawyers became annoyed: the world [referring to system] has become infeasible. Well, the municipalities couldn’t be steered otherwise than through legislation, because of the principles of municipal autonomy. Earlier, it was done through national planning and steering

⁷ http://www.thl.fi/fi_FI/web/fi/tiedote?id=30059

system and the laws were very loose and they were specified in the Government Resolutions, and...or in decrees and in the Government Resolutions and...(--) After that, there wasn't any other way to do that, in this stream of steering instruments, than to start a project or a programme, or we had to change legislation, which is always, irrespective of how small the change would be... And in that kind of environment where the municipal side is objecting and claiming that they are anyway going bankrupt, it was...I remember that I said (--) this is so pointless, we have to shoot a mosquito with a cannon, even a small change requires excessive measures. (--)" CS3

"(--) Well, the political change happened of course, one could say that, well, in the beginning of the 1990s when we ended up abolishing the 5-year planning and the state subsidy system was re-built in the way that it gave everything to municipalities. The reasoning in the end of the 1980s was that we have now built and finished the social and health political system and it works fine, so we could think that municipalities are capable of making decisions which concern them, that they are (--) We don't need a direct and strict state control which we had before, and in a way one could say that the "municipal party" in the Parliament won and the state steering mechanism became quite soft. And of course, after that, one can say that when we joined the EU and we slowly started to notice the effects here as well, that also market steering mechanism was born at the same time, only then (--) the situation started to change and we started to buy services from private operators, and it changed the balance of decision-making towards local government and lower administration, I mean regarding the service system. (--)" CS4

There seems to be a quite strong juxtaposition between the state and municipalities, to some extent also at municipal level. On the other hand, from a citizen's point a view, they both represent public sector but from the viewpoint of the state or municipalities, they are not the same. The composition is made of "them" and

“us” and sometimes it is difficult to avoid the feeling that for some people or parties, in a broad sense, own dignity and interest may be more important than trying to find functional solutions, or at least health issues are not necessarily very high on priority list.

The conflict is visible at several levels and regarding both sides:

“(--) Well, there [in municipalities] are certain basic things that work well, but if you think about politics, both responsibility and blame are tossed around tremendously. For example, at first we say that we understand health policy as societal policy and then, in fact, the state turns it around so that health policy is mainly executed by the municipalities, well, it is... it's done more or less sporadically... For instance, the responsibility for decreasing disparities in health is often thrown to municipals although they do not have many instruments to do something about them (--) I see that it goes in a way so that, well, the heads of municipalities want more degrees of freedom but not necessarily... let's say the health politicians or...the health experts of the municipality, they would like to have the state backing them up (-) The tension at the local level, and of course the same tension between ministries; it is troublesome for the Ministry of Finance if the MSAH is scheming with the municipalities something that costs (--) But rhetorically the self-government has been constructed as a somehow peculiar detachment and...this autonomy is constructed as self-government of the local authorities and not as self-government of the citizens. ” R5

“(--) Well, we have, I mean, from the municipal perspective, there are two things: on the other hand service systems which are municipal, except for the private sector growing all the time, and on the other hand, the fact is that a municipality is kind of a horizontal body. For instance, regarding health promotion, the municipality decides on housing policy, education policy, urban planning, et cetera, and well... the state authority is steering all this through legislation but

precisely after the state subsidy reform, this resource steering has been non-existent and then... How the state controls municipalities, that is one question. At the moment it is quite often THL, but many [municipal] health professionals in municipalities would like to have the National Board of Health back, to say what to do... In a situation, where the system has fell to pieces, many people would like to see stricter state control (--)" O2

There was a slightly differing understanding regarding the authority of municipalities over the costs of primary and secondary care. Some respondents regarded the municipal budget as an entity, therefore stating that it is totally possible for the municipal councils and governments to remediate the situation. One respondent believed that higher-ranking municipal politicians participate in the decision making of hospital districts, whereas the boards of health centers are left for inferior politicians. This perception was, however, disproved by couple of respondents. One of them described the problem in budgeting for primary and secondary care, and also the tension between public and private care, as follows:

"(--) Because, well, the hospitals receive referrals and they have to be taken care of, and the municipality will receive the bill. There are no alternatives for the municipality, they have to pay. Municipalities have always tried to under budget and then in December... they have to pay for that, well, they just exceed their budgets. And if they don't exceed the budget, like "we are not going to take care of this hip surgery", the MSAH will sanction them, so regarding expenses, it is a perfect vending machine because, well... And of course the municipalities could think that they would instruct health centers so that they wouldn't send each patient to the hospital, but the private firms will, and the municipalities have to pay for also those referrals... (--) The operations of hospital districts is not in the hands of their boards at all, they can't do anything about the situation, and well, if in the municipality, if they would have know-how in municipal healthcare, they would invest in health centers so that the citizens wouldn't have

to go the central hospital. Because when you have ended up there, you can't leave even if you would have been just accompanying someone. So they will examine everything, like, if you have originally been referred as a hip surgery patient, they will definitely examine also your insomnia problems and all kinds of things, and well...of course there have been these pathetic attempts to reduce capacity, like "should we close a ward", as if there were less hospital beds, and then they have closed a ward and had beds in the corridors. So it won't help at all. (--)" O3

Many respondents emphasised that not all municipalities are the same but there are at the moment 336 different actors. It was said that municipalities have a great freedom to do almost whatever they wish and there are municipalities which are excellent in terms of health: they invest in health promotion and they have expertise. However, there are still municipalities, which were seen "not to care" or they simply do not have enough resources, which was seen to be linked to the size of a municipality.

Kerttu Perttilä's doctoral thesis (Perttilä 1999) is one of the most comprehensive studies on municipalities and health promotion. Perttilä discusses health promotion in municipalities from various viewpoints and e.g. regarding the recession in the 1990s, she found two types of influence. It increased community-based activities and municipal emphasis on shared responsibility and co-operation. On the other hand, due to lack of resources, the recession limited the operational possibilities. Perttilä's study showed that while health promotion has been discussed in strategy documents, it is not necessarily a very clear concept or framework among municipal decision makers or even among heads of municipalities. The confusion tends to lead to incoherence in strategies and to forgetting health aspect in decision making. At the same time, the municipals are using more private service producers, which is challenging for the municipal leadership, especially regarding research and gathering information. In many cases, the municipal operations are increasingly fractioned, which may lead to the state of uncertainty and lack of the big picture; in the worst case no one sees the whole system and ensures that all

crucial tasks are being taken care of. There is not much research done on implementation, organising or effectivity of health promotion activities executed on the healthcare sector, which is one of the reasons behind the absence of a shared understanding what health promotion is and how municipalities can advance health promotion initiatives. (Ståhl & Rimpelä 2010.)

The number of programmes, projects, and also overlapping and incoherent demands were seen to cause fatigue in municipalities:

“(--) Well..., if I say something based on what I’ve heard from municipal representatives, they are quite tired with all kinds of overlapping programmes and instructions and regulations that they receive, and part of them are even, like, impossible to execute, such as the already mentioned obligation to monitor the health and welfare of population or citizens and to monitor the attributes per population groups. So for instance, how do you monitor the development of obesity in your municipality, how do you...You don’t have that kind of information... So before one declares that municipalities must do this and that, there should be information that it is doable in the first place, or at least one should plan some kind of process, which would lead to those circumstances that would allow municipalities to do something. I find it a bit confusing that legislation always sets obligations, which are absurd in the sense that they are not realistic, that one cannot even...(--) R2

It was interesting to notice that while the Association of Finnish Local and Regional Authorities is the representative for municipalities in Finland and participates also in many governmental working groups and committees, it very rarely appeared either during the general discussion on municipalities’ situation and role in Finnish health policy, or regarding the Health 2015 process. The position of the Association was seen controversial, and at least not very influential in health policy. One respondent summarised the mutual view as

“(--) In practice, the Association of Finnish Local and Regional Authorities represents the interests of municipal economy, not the interests of municipal citizens, it’s a huge difference (--). CS3

Despite the stated lack of control and steering instruments of the state and the dubious role of programmes and projects, there can also be found efforts for improving the situation. The programmes and projects have been criticised for temporality so the MSAH and THL have tried to focus on projects creating stable structures and networks at the municipal level. One project that was mentioned as an example of a new kind of approach is the Healthier Northern Finland⁸ which is now slowly expanding to the whole country.

7.4 Public health and nongovernmental organizations (NGOs)

Finland is often called a land of a thousand lakes, although the latest number is over 180 000⁹, but Finland could also be called a land of NGOs. According to the National Board of Patents and Registration in Finland (2012), some 133 000 associations have been registered with the Register of Associations. The NGOs have been a significant part in creating the Finnish welfare society and the oldest ones have been founded already in the 19th century. There are approximately 8000 NGOs which operate on social and health field. Most of the NGOS are local or regional and they are largely run by volunteers, but approximately 200 NGOs operate nationwide. In addition to the existing ones, it has been estimated that every year 100-200 new social and health NGOs are registered. (Lindqvist & Vuorinen 2009.) NGOs may have different functions, such as interest representation and influencing policy makers, peer support, volunteer work, and producing and developing services and innovations. The role of the Finnish NGOs in political decision making is notable also from international perspective.

In my research, most of the interviewees found health and social NGOs important for Finnish health policy. A few persons said that the role is unfortunately perhaps

⁸ <http://sp.terps.foral.fi/default.aspx>

⁹ <http://www.ymparisto.fi/default.asp?node=8103&lan=fi>

not as strong as it should be, but most of respondents saw that social and health NGOs definitely have a role in Finnish health policy and they influence decision making and agenda at several levels. The respondents reminded about the historical importance of NGOs; they have traditionally generated innovations and activities which have later been adapted into public health sector, such as maternity clinics, tuberculosis and breast cancer monitoring. NGOs have also participated in public health campaigns; for instance the Martha Organization¹⁰ was active in the 1970s and educated women, thus the whole family, on healthy nutrition and the importance of exercise. The Marthas launched the very first monitoring diary for breast cancer, which every woman could order for 1 Finnish Mark [1.07 € in 2011]. The NGOs also influenced the National Board of Health. The Board had an extensive group of professionals, all leading professors from different medical fields, and it also had various committees for several health sectors. In that way, the NGOs were indirectly able to affect the decision making of the Board.

In general, the informants divided the NGOs in two categories: public health organisations and disorder-based patient organisations. Many organisations were mentioned to belong to both categories but several respondents wanted to make a clear distinction between these two types. The organisations which appeared during the interviews the most often were the Finnish Heart Association, the Finnish Diabetes Association and the Cancer Society of Finland. However, also the Finnish Rheumatism Association, the Finnish Central Association for Mental Health, the Finnish Epilepsy Society, the Allergy and Asthma Federation, the Breathing Association and the Finnish Lung Health Association Filha were mentioned. One person wanted to question the position of the Finnish Patient Organisation among other health NGOs. In his opinion, despite the name, this organisation does not represent Finnish patients; the member organisations are very small and some disorders and conditions under its representation are contested in medical terms, such as electromagnetic hypersensitivity.

¹⁰<http://www.marttaperinne.fi/aikajana/1970/terveys-ennen-kaikkeala/>

The dichotomy of the NGOs was visible for instance when discussing the role and objectives of the organisations. Everyone saw disorder-based organisations as interest organisations and they were often compared to trade unions. On the other hand, the general public health organisations were seen as interest organisations, as were also research, research funding, service production, disease prevention, and care. The miscellaneous tasks and roles were seen also as a problem; several respondents mentioned that certain NGOs are patient organisations defending the rights of their members but they also try to influence societal policy and produce services e.g. at the municipal level. At municipal level, health promotion and disease prevention were mentioned to be in the hands of the NGOs and the municipalities benefit from the organisations in many ways. One respondent commented, however, that perhaps not as much as they could.

The largest and oldest NGOs have many members, plenty of resources and their operations are well organised at both national and local levels. The organisations are mainly funded by the Finland's Slot Machine Association (RAY). Some respondents commented that the RAY funding and the establishment that has followed are both good and bad; it has secured the operations, strengthened the NGOs and enabled them to become a major health policy actor, but on the other hand it was seen that they have become "toothless" towards the MSAH and RAY – no one wants to bite the feeding hand. Although Finnish consensus was seen as desirable per se, a few respondents wished for a more critical approach.

Several NGOs have policy documents and they usually publish their goals for municipal and parliamentary elections, but one respondent believed that they are mainly aimed at the members to show that the NGOs are indeed defending their cause. He also saw that NGOs lost their nongovernmental watchdog capacity in the 1970s and 1980s due to RAY funding and shift towards service production. Another person commented that he has not seen any radical policies or demands and in his understanding, the NGOs more or less follow the official objectives of Finnish health policy.

Although public health NGOs were seen to influence societal agenda and being major actors, many respondents commented that in fact, it is quite difficult to measure the actual influence. Some persons commented that at institutional level, it is possible to operate through NGOs and to accomplish things that would not otherwise happen. The image of NGOs has been positive and they have been able to recruit capable professionals, not to mention the extremely important role of health experts in volunteer positions.

One interesting feature, which was mentioned by several interviewees, is the amount of high-ranking health professionals and opinion leaders in the boards, usually as a chairperson of the NGOs. One group consists of specialists, usually professors, senior physicians or other distinguished professionals in the respective field, including the directors and researchers of sector research institutes. Another group consists of politicians, and a few people commented that in the Parliament, there is a public health NGO “party” and one does not become a MP without having chaired some NGO. It was perhaps an exaggeration, but not necessarily extreme.

All in all, this means that social and health NGOs have usually wide networks among professions, professionals, and also in the Parliament so the influence and power may be hidden. Through their political connections, the NGOs, or at least their objectives, were told to be participating in the negotiations for the Government Programme as well.

Usually the loudest interest organisations have the most significant influence on societal agenda and compared with industry or trade unions, social and health NGOs were not found as influential. However, several persons mentioned that the industry finances some NGOs so again, it may be challenging to know and recognise the channels of influence. Especially pharmaceutical companies were mentioned in this context and some informants mentioned that when representatives of an NGO are called for a hearing of a parliamentary committee, for instance to consult on suitable treatments and medications, it may be that in fact,

the content comes from the funding company and it is just presented as an opinion of the NGO. Another example was the food industry which was mentioned to collaborate with certain NGOs. In 2000, the Finnish Heart Association and the Finnish Diabetes Association launched a Heart Symbol¹¹, which tells a consumer that the product is a better choice in its respective group regarding fat and sodium. The symbol is recognised by authorities and Heart Symbol products are recommended e.g. in the dietary guidelines given by the National Nutrition Council. This kind of collaboration is quite transparent, although not totally without problems.

Despite the unanimous view on the representation of interests, a few interviewees mentioned their positive experiences regarding their professional cooperation with some NGOs. They were wondering, if the attitude and culture are slowly changing and if NGOs have considered that instead of promoting and advocating their own agenda, usually relating to one disorder, it might be more fruitful to take a wider societal perspective. In reference to these observations, several informants mentioned the new umbrella organisation, SOSTE Finnish Society for Social and Health. SOSTE was established in the beginning of 2012 when three collaborative social and health umbrella organisations were merged.

SOSTE defines itself as follows (SOSTE Suomen sosiaali ja terveystyö 2012):

SOSTE Finnish Social and Health is a new national umbrella organisation which connects over 170 social and health NGOs and several dozens of other cooperating partners.

SOSTE is, with its member organisations, a courageous agent and an authority whose objective is to make people feel better. In cooperation with our members and various actors we will create opportunities for social welfare and health, for participation, and fair and responsible society. (--)

¹¹ http://www.sydanmerkki.fi/sydanmerkki_tuotteet/etusivu/fi_FI/englanniksi/

The interviewees commented that this development and the merger was a very good thing. It was seen to increase cooperation among the organisations but also to enhance the influence of these NGOs. The interviewees appreciated this kind of joint venture, and it was seen to potentially reduce the earlier experienced narrow-mindedness of disease-oriented organisations.

With respect to the MSAH, NGOs are in an important position. Many individual organisations, but especially the new SOSTE, have an almost automatic seat in committees, working groups, seminars and similar preparatory bodies. The MSAH also consults RAY so there is a connection between these three actor groups. From the MSAH viewpoint, NGOs are considered valuable experts and in many cases, such as small patient or disability groups, the NGOs are regarded to have the best knowledge. NGOs are also requested written statements regarding legislation and other issues that the MSAH processes. However, the role of NGOs as interest representatives is recognised in the MSAH. For instance, regarding the process of Health 2015, some interviewees commented, and it was partly visible in my research documents as well, that the Advisory Board for Public Health was cautious about NGOs. It was known ahead that organisations will be active and the Advisory Board, or certain members, wanted to avoid the situation where they end up writing separate programmes for each and every disorder. Instead, the NGOs were heard and their statements and working papers were taken into account, but the Advisory Board wanted to look for the common factors behind chronic diseases and concentrate on them. The reasoning was that if these background variables can be influenced, it would decrease the prevalence of each disorder also without a separate programme just for that disease. For Health 2015 and participants, see Chapter 8.

Finally, it was also mentioned that RAY funding has decreased, which affects NGOs. The largest and oldest organisations are relatively wealthy, but the cuts were mentioned to affect especially the newer and smaller organisations.

7.5 Trade unions

The theoretical framework for the role of trade unions and other corporatist actors in Finnish policy making was presented in Chapter 3. Regarding Finnish health policy, the most relevant actors seem to be found in trade unions; employer's organisations did not play any particular part in my study. There are several health, social, and welfare related trade unions in Finland, and they represent either specific professions or the field in general. Some of them also cover interest representation for both professional development and wages. However, some of them are mainly a connecting platform for their members, sharing information on education and work life, but they have outsourced the wages and contracts to a labour market organisation or to another health and welfare organisation, such as Tehy. These organisations may represent members operating on public, private or both sectors. Their members may also change from one union to another, for instance when changing jobs, so there may be same member groups and job titles in several organisations.

Nevertheless, despite a slight overlap and incoherence, I will list the most relevant organisations below. I will also give a short description of those two which were mentioned the most often in my interviews, The Finnish Medical Association (FMA) and Tehy, the Union of Health and Social Care Professionals. Apart from the FMA and Tehy, the others are in alphabetic order. Most of the translations are taken from the respective websites, but all organisations did not have any official name in English so I have translated them following international convention.

- The Finnish Medical Association (FMA) was established in 1910 and it is a professional organization for physicians. In the beginning of 2011, the FMA had 23 130 members, 1 535 of whom were medical students. In all, 94% of physicians living in Finland belong to the FMA. Values promoted by the Association include advancement of medical expertise, humanity, ethics, and collegiality. The FMA binds its members together to support these values, and represents their common professional, social and economic interests. (Finnish Medical Association 2012.)

- Tehy, the Union of Health and Social Care Professionals was established in 1982. Tehy represents qualified health care professionals, social workers and students of these professions in both private and public sectors. Tehy has over 150 000 members and it is the largest trade union in these fields in Finland. (Tehy 2012.)
- Health Science Academic Leaders and Experts (Taja)¹²
- The Association of Biomedical Laboratory Scientists in Finland¹³
- The Federation of Public and Private Sector Employees (Jyty)¹⁴
- The Finnish Association of Community Health Nurses (STHL)¹⁵
- The Finnish Association of Ergotherapists¹⁶
- The Finnish Association of Occupational Health Nurses (FAOHN)¹⁷
- The Finnish Dental Association¹⁸
- The Finnish Nurses Association¹⁹
- The Finnish Union of Practical Nurses (SuPer)²⁰
- Talentia²¹
- The Trade Union for the Public and Welfare Sectors JHL²²
- YSTE²³

¹² <http://www.taja.fi>

¹³ http://www.bioanalyttikoliitto.fi/in_english/

¹⁴ <http://www.jytyliitto.fi/Sivu/in-english>

¹⁵ <http://www.terveydenhoitajaliitto.fi/>

¹⁶ <http://www.toimintaterapeuttiliitto.fi/>

¹⁷ http://www.sthl.net/fin/in_english/

¹⁸ <http://www.hammaslaakariliitto.fi/index.php?id=6404>

¹⁹ http://www.nurses.fi/the_finnish_nurses_association/

²⁰ <http://www.superliitto.fi/en/>

²¹ <http://www.talentia.fi/en/>

²² http://www.jhl.fi/portal/en/about_jhl/

²³ <http://www.ystea.fi/ystea/mikonystea/>

In general, a few comments need to be made. First of all, I will remind at this point that the focus of my study is health policy instead of healthcare policy and therefore I had formulated the research questions in the same manner. It seems that also the trade unions themselves recognise the difference, and health policy is indeed more often understood as healthcare policy in their vocabulary. Their focus is on healthcare service system and its structure and funding. The organisations see themselves as professionals and experts which are naturally interest organisations, but their expertise and societal position are understood to stem from the substance.

Secondly, as I have not done any network analysis, these results do not indicate the absolute truth on power relations between different corporatist actors or quantitatively verified amount of influence. Nevertheless, they can rather be seen to reflect the image of these actors in public policy making and societal interaction; in that capacity, they are valid.

The overall perception of trade unions, especially the FMA and Tehy, was that they have influence and they are a significant part of Finnish policy making. As one respondent phrased it, there is no reform made without consulting trade unions. Everyone emphasised that trade unions are primarily interest organisations and their objective is to take care of the interests of their members. One respondent commented that one way of interest representation may be to try to gather as many influential societal posts as possible, and generally speaking, the common good was not seen as their primary interest.

There was a mutual view that at the national level, and especially when understanding health policy in a wider sense, Tehy does not have much influence. However, regarding the FMA, the opinions were divided: some respondents saw that the FMA is very influential, a good lobbyist and it is also listened to. On the other hand, some others commented that the FMA has been surprisingly weak. One thing was evident: everyone had an opinion on the FMA.

However, as was the case with NGOs, the amount of actual power is difficult to estimate and the “hidden influence” was mentioned. The channels of influence

were, again, considered partly invisible. For instance, considering the MSAH, one respondent commented that the FMA has good relations with many civil servants who are medical doctors and, as has been already mentioned, this profession is quite well represented in the administration, which may give the FMA opportunities for hidden leverage. On the other hand, for the MSAH and other ministries trade unions are key stakeholders which offer expertise. If these organisations do not support the political initiatives or if they are not able to get their members involved, implementing any kind of healthcare innovation or reforms is difficult.

A few interviewees said that in their opinion, the most significant problem is the narrow-mindedness of trade unions. One person wished that these organisations would be braver and look into the future instead of jealously defending their own territory and boundaries of their members' profession. The world is changing and the inflexible profession segments that may have worked in the 1970s and 1980s do not work in the 21st century. The reasoning was that modern health care needs various types of knowledge and genuine teamwork would improve the current situation. Another person commented that especially at the municipal level the trade unions are important, but they also usually object everything. He mentioned that all kinds of reforms are almost impossible, even if they would be urgent and important, because the trade unions only want to guard their own territory and do not care about the big picture.

As I have written earlier, the physicians and especially FMA have played a significant role in creation of Finnish healthcare system. In a way, professions have struggled for same, scarce resources, which can be detected in the current situation.

“(--) Tehy does not present any health policy initiatives and there is no health policy thinking. Tehy is concentrating more on internal affairs. Regarding FMA, on the other hand, the historical change of Finnish health policy affects their operations. Health policy has been healthcare policy since the mid-1980s, there is somewhere something vague “health promotion”, but health policy focuses on physician-led health care. All the discussion concerning structures bases on how

we should organise the work of medical doctors. In the 1970s, we still discussed teamwork but since the 1990s, we have just been talking about doctors' work and how it should be organised. Only recently, multi-professionalism has again been remembered; there are also other professions than doctors in healthcare sector. But, the doctors are anyway working in their own hierarchy and the rest in their own (--)."R1

One central type of influence was mentioned several times: a strike threat. It was especially mentioned in reference to the FMA, and a few persons stated that in their opinion, the role of the FMA changed after the physicians' strike in 2001. They mentioned that due to the strike, the FMA was able to win higher salaries for medical doctors, but at the same time they were disowned by the politicians. The perception was that since then, instead of an expert organisation, the FMA has been considered only as an interest organisation. This opinion was not, however, shared by all. Some people recognised a longer "quiet phase" and a lower profile, but they saw that the FMA still has good connections.

Besides strike, also the current shortage of physicians, or the perception of shortage of physicians, was seen to originate from the self-interest policy of the FMA. A few interviewees commented that the FMA has systematically objected the increase in the number of students entering the Faculties of Medicine, to secure its status. They mentioned that due to a physician Minister and some physician civil servants in the 1990s, the number of entries was indeed decreased. Nevertheless, some others commented that the disastrous situation is also partly caused by the imbalance between medical doctors working in the public and in the private sector, and also because there are more female physicians than before; they often want to work less to combine work and family. Also junior doctors may prefer working less or choosing their position more carefully; the patients may be more challenging in certain areas and if there is no senior support available, junior doctors may be scared of the responsibility. On a more general observation one could say that the attitude has changed as well; the idea of a doctor serving their country and partly sacrificing him/herself for a common good is not reality anymore.

Also promoting healthcare privatisation was mentioned as one feature linked to the FMA, and it was considered as an organisation which represents mainly physicians working in the hospitals or in the private sector. Of a more historical point of view, one respondent said that he feels that the FMA has actually been off on a sidetrack since the 1970s, when they were objecting the Public Health Act in 1972 and lost. Since then, he added, the only role has been of a barking dog.

Although the FMA was seen in a slightly negative way in general, one respondent summarised that the FMA has existed for over 100 years and it has been both supporting and opposing various public health initiatives; sometimes in cooperation with the MSAH and the Government and sometimes on the other side.

In terms of professions, it is typical that the members of various interest organisations do not see themselves as political policy makers but instead, they see themselves as “outsiders”, neutral experts and professionals (Kantola 2002). Physicians as a profession are also an interest group and as the role of medicine has constantly grown in our modern society, doctors are considered as highly respected and also trusted experts. The medicalisation of the society has changed the doctor – patient relation (e.g. Conrad 1992), the patient has become a consumer, and also increased influence of media generates pressure. The professions are aiming at maximising their own autonomy, the autonomy of expertise, and at preventing the interference from the state. In some countries, various health system reforms, especially health insurance reforms, have been seen as a threat to the medical profession. (E.g. Immergut 1990, 1992; Southon & Braithwaite 1998.)

In his doctoral thesis, Arttu Saarinen investigated the role of the FMA and the physician profession in Finnish health policy (Saarinen 2010). The FMA is presented (e.g. *ibid.*, p. 34-35) as a health policy expert and as a strong interest organisation. Saarinen evaluates different viewpoints on medical profession and how the relation between doctors and health policy has been investigated (*ibid.*, p. 25-33). In his research, the political stand of physicians was the strongest variable and explained the differences of opinion. Other variables which had effect were working on the private sector, gender, or if the physicians had specialised or not. Saarinen has made several interesting observations, and one of them is that those members

who were active in the FMA and interested in health political activities, were more willing to cut social services compared with non-activists (ibid., p. 62). Saarinen found (ibid., p. 63) as well that in general, physicians want to increase the role of private sector on average less than the citizens. According to Saarinen (ibid., p. 57), the positions and rhetoric of the FMA resemble those the National Coalition Party. Since the 1970s, FMA has accentuated the private sector as a part of the public service production system and it has also favoured marketisation. The views of the FMA are not very often similar to those of an average FMA member (ibid., p. 63).

Whether the FMA is conscious of these kinds of perceptions or not, they have anyway created a new strategy in 2010 (Suomen Lääkäriliitto 2010).

The FMA considers itself “more than a trade union” and the main messages of the new strategy 2010-2017 have been summarised as follows (translation by JV):

- FMA is modernised – a new union
- Towards the member
- From an opponent to a partner
- For the best of the patient
- A sustainable economy

The central idea of partnership and mutual cooperation recurs in the strategy documents and presentations. It seems that the FMA is well aware of the difficulty and challenges of this kind of mindset reform, especially taking into consideration that most of the staff remains the same. According to the FMA, they see that their role has strengthened and the new strategy has been well accepted. Naturally, all interest organisations are to some extent prisoners of their roles, but the FMA sees itself as an expert that represents both private sector and public sector physicians, and both employees and employers.

One specific event, which can be regarded as an incarnation of the new policy, was discussed in some interviews: a joint editorial with the Pharma Industry Finland (Merikallio & Pärnänen 2012). In general, the close relations between physi-

cians and pharmaceutical industry have been both necessary and problematic. Both parties are experts in their respective fields, but in the first place they are interest representatives. Therefore, this kind of a joint statement may be very risky and it has indeed aroused discussion at least among the FMA members. The outcome and acceptance of these kinds of manoeuvres will highly depend on how well the FMA is able to communicate its new strategy and, at the end of the day, how well the new mindset will truly penetrate the whole organisation and its activities.

Tehy, Union of Health and Social Care Professionals, was mentioned in the interviews in a more neutral tone than the FMA. Some respondents merely wondered why Tehy has not been more active or visible in societal context, but the general stand was either neutral or positive. Tehy's role was seen to be operating mainly at the municipal level, but no one saw that it would be a strong opinion leader in health policy at the national level.

Some respondents mentioned the difference between nursing science and nursing as health care. The nurse organisations in general were not seen very strong, and one person commented that they have not held such a balance of power than the FMA, although Tehy has tried. Regarding implementation of Finnish health policy, one respondent mentioned that the nurses have always been quite receptive and active. For instance, nurses were mentioned to have accepted the Health for All by the Year 2000 programme quite well, perhaps due to their training which focuses on health promotion, preventive work, and working in a family centred way.

There was only one person who presented an analytical view on why Tehy and other healthcare organisations may have been in a weaker position compared with the FMA:

"(--) Well, if one understands health policy in a comprehensive sense, perhaps the most significant change became in the beginning of the 1980s, this dispute over statutes [in hospitals], when this, kind of a compromise decision was made. The healthcare leadership was di-

vided in three parts: financial administration, nursing administration and medical administration. At that point nursing marginalised itself into managing care. In other words, I see that after this reform Tehy or the other representatives of nursing, have had quite few health policy initiatives, so they have just nestled in nursing and the field has been left to the FMA (--).” R1

One, although a bit separate issue appeared in two interviews: the role and position of the Finnish Medical Society Duodecim. One respondent was pondering if Duodecim could be even more influential than the FMA. Another one considered it strange that the MSAH has allowed Duodecim to operate on the Current Care Guidelines and in his opinion, this is marvelled in some other countries; *“is the FMA still that influential in Finland?”* In any case, the other interviewees did not see the role of Duodecim problematic because the possible competing interests are announced and listed with each recommendation. Duodecim is a scientific society and it was described to enjoy high levels of trust, so some respondents believed that Duodecim cannot afford to jeopardise its excellent reputation by allowing dubious recommendations. Also, Duodecim was said to be the initiator for these evidence-based recommendations and without its activity they would not exist due to lack of resources in the MSAH and THL. A few respondents commented that also THL has connections to pharmaceutical industry, so in their opinion the position of disqualification would not be significantly different if THL administered the recommendations.

7.6 Industry

One of the most challenging aspects in making societal policy, besides increased stress on individualism, is the fact that health-related values and solutions may conflict with other policy objectives. Very often health and industry interests are on opposite sides of the plate, tobacco and alcohol being the most obvious examples. (Koskinen et al. 2002.) Why, then, the private sector is such a powerful actor in health policy? Buse et al. (2005, p. 57-61) write that private sector is often a major employer in the economy, and companies also have specialist knowledge

which governments rely on in making policy and regulations. Private sector is often involved in public policy making and they also fund political parties and campaigns (c.f. Hillman 2003, p. 416-419). According to Buse et al. (2005), those with enough power are able to stop items reaching the political agenda and also able to shape people's wishes so that only issues deemed acceptable are discussed.

As Deborah Cohen (2011) writes, especially the international pharmaceutical industry has been very powerful. For instance, although noncommunicable diseases (NCDs) are globally a major health problem, Acquired Immune Deficiency Syndrome (AIDS) has raised more attention than NCDs because it has a higher profile for campaigning. Making better choices for health is not unambiguous; for instance decrease in meat consumption may improve health somewhere but cause decrease of income and vicariously worsen health elsewhere. However, protecting economic interests seems to be a more important obstacle and e.g. in the EU, the food industry lobbies were able to prevent the implementation of so called traffic lights. There are also other examples to prove that industry has been able to influence Governments and to decelerate effective health policy.

A need for a code of conduct for industry cooperation has also been presented at the UN level. In respect of alcohol policy, the industry has in some cases been successful in lobbying and affected legislation so that effective evidence-based measures, such as controlling prices and marketing, have been replaced by industry favoured measures, such as community actions and partnership working. The global public health civil society has been hoping for tougher restrictions to help them to fight NCDs, but especially the US has been powerful in lobbying for voluntary targets. Cohen (2011) refers to Richard Smith from the London School of Hygiene and Tropical Medicine who has commented that although health ministers may be convinced that "the health of the country is the wealth of the country", the biggest challenge lies in trying to persuade influential actors in trade, industry, and budgetary offices in international governments.

My findings are in accordance with literature. One respondent summarised the circumstances as follows:

“(--) Well, it is a fact that we are living in a world which is constantly commercialising, and commercialisation has a growing effect on the health of the Finns, in positive and negative ways. The question is, how we are involved in this process, how we can support these positive things.(--) We are talking about the balance between regulations and other actions, this is continuously... there is alcohol policy, tobacco policy, nutrition policy, which we have to think about all the time. (--)” O2

In my interviews, the industry and private sector in general was unanimously seen as a powerful agent and active and proficient lobbyist. The overall impression was not very positive and the main objective was described as “to sell as much as possible and to gain as large profits as possible”. Industry lobbies were said to influence public agenda, what the decision makers speak about and the way in which issues are addressed. Especially the indirect impact on thinking was mentioned in the context of health care.

Private sector activities were described as “hard business” and one respondent commented that the firms and interest organisations use all the stakes to scare political decision makers. One person mentioned that the industry has one problem; it has not joined forces but all the domains and firms work separately trying to win as much as possible.

As I have written already earlier, especially pharmaceutical and brewery industries have been strong in Finland. Tobacco industry was said to be weaker than in some other countries, such as Germany, and several persons called the Finnish Tobacco Act and its amendments to be a great Finnish public health success story.

The Finnish industry was described to perpetually oppose all reforms, and if the firms or interest organisations have not been able to stop the process, they have at least usually been able to decelerate amendments. As was the case with public health organisations and trade unions, also industry was described to have invisible channels of influence and the true power may be difficult to estimate.

Although capable, healthy workforce is prerequisite for a successful business, some interviewees commented that the industry and business life have shown surprisingly little interest in this connection. For instance, occupational health care was initially created for prevention and health promotion, but it has merely become workplace medical care.

The industry was said to be lobbying especially the Insurance Department of the MSAH and also to some extent the officials responsible for vaccine issues. From the Ministries' and THL viewpoint, interaction and communication with industry representatives is challenging and needs careful consideration. On the one hand, it may be essential to have all potential parties involved in policy making and reform processes to hear what they think, what kind of priorities they may have and to commit them to the current issue. On the other hand, to avoid bias and incapacity, it may be needed to keep industry and interest organisation at arm's length. The risk for evoking doubt lies especially in communication with pharmaceutical industry, and the most recent episode which raised public attention was caused by Pandemrix vaccine against H1N1 swine flu, narcolepsy cases and the contract made with GlaxoSmithKline.²⁴

The pharmaceutical industry was said to be influential in all countries and stronger in the EU than in the Member States. Also WHO has undergone battles in terms of clashing interests between industry and global health. Finland was mentioned to be in a quite good position because there is no domestic "giant pharma", so e.g. controlling drug expenditure to decrease financial burden of households and enabling generic drugs have been more successful in Finland than in some other countries. It has not been effortless, though; one person mentioned that during the preparation for the new law on generic substitution in the beginning of the 2000s, even one foreign embassy approached the MSAH several times with "almost threatening letters".

Pharmaceutical sector is represented by Pharma Industry Finland PIF which was called a strong lobbyist as well. The direct contacts between pharmaceutical in-

²⁴ THL 2012; Heikkilä 2011

dustry and physicians in Finland were defined as exceptionally strong. One respondent commented that this kind of close cooperation would not be allowed in many other countries. The industry is very active and especially if the minister is “weak” or does not have much experience, the industry was said to try lobbying even harder.

As I reported already in Chapter 7.4, the public health NGOs were said to be connected to pharmaceutical industry. However, there has been some monitoring of these connections and NGOs have tried to clarify their own ethical principles, but one respondent suggested that this subject should be investigated further.

In general, having a balanced discussion on medical treatment and the associated phenomena is difficult. It is perhaps self-evident that drugs are important and there are many conditions that cannot be treated without proper medication. It would just be essential to find the right medicines and to give them to the right patients. However, several respondents commented that especially regarding statines and other cholesterol lowering drugs, the situation has definitely gone too far in Finland, and some interviewees also mentioned drugs lowering blood pressure in the same context.

On the other hand, the changing, and already changed, doctor – patient relationship, effects of medicalisation and the influence of media was discussed in many interviews. Several persons commented that although a physician would like to keep distance from industry, the patients, or customers, as they are often called nowadays, may come to the appointment with a diagnosis and a list of drugs and they dictate what kind of medication they would like to have, sometimes even concentrations. When a doctor has perhaps just 10 minutes for each patient, he or she may feel pressure to write a prescription, especially in the private sector where it is important to serve the customers well to make sure they will use the services also in the future.

Regarding alcohol policy issues, several persons mentioned or confirmed that the National Coalition Party has close relations to The Federation of the Brewing and Soft Drinks Industry. I was told that in their understanding, the industry is support-

ing at least the National Coalition party but perhaps also the Center Party. The last three Managing Directors of the Federation have come from the National Coalition Party and/or these persons have worked closely with the party.

Excessive use of alcohol is indeed one of the major threats to the whole Finnish society. However, the discussion is quite heated and the MSAH, THL, and other parties which are defending regulations and restrictions are easily labeled overly paternal and restricting individual rights and freedom. On the other hand, the industry lobbies forcefully and there is a constant battle between these two sides.

The current situation is summarised well in these quotes:

"I feel pity for anyone who becomes the 'booze minister'", exclaimed one respondent spontaneously and another formulated the general opinion as follows:

"(--) well, brewery has been totally... it is catastrophic, the Federation of the Brewing and Soft Drinks Industry has led Finnish alcohol policy for a long time. (--)" CS3

The views on nutrition policy and food industry were neutral or somewhat more positive than the industries addressed above. The interests of the food industry were not seen totally trouble-free, but in general this sector was considered to play better along with the decision makers and health experts.

It seems that despite agricultural policy and various subventions, the Finnish nutrition policy has been quite successful in terms of health. As was the case with tobacco policy, the balance between interests of agriculture vs. nutrition was described as being not as problematic as in some other countries. Nevertheless, Finland has indeed seen a couple of rounds of so called "fat wars" which has occasionally tightened relations between public health professionals, researchers and food industry. Finnish food industry can be regarded to have executed self-regulation (Buse et al. 2005, p. 58-60) more than other industry domains.

Some informants saw that in a way it is good to have food industry in the National Nutrition Council drafting national recommendations with health professionals and nutrition experts and thus to commit them to developing products which are

better for health. A couple of positive examples were given, both from HK Ruokatalo Oy: rapeseed pork, launched in 2011, and reduction of salt in several products. The former refers to a new kind of feed which contains rapeseed oil and therefore changes the fatty acid content of meat. Most of the fat in rapeseed pork is unsaturated and it contains more omega-3 fatty acids than ordinary pork, which follows the Finnish nutrition guidelines. Since its launch, HK Ruokatalo has sold over 20 million kilograms of various rapeseed pork products, which means approximately 110 000 kilograms less saturated fats compared with same amount of regular pork. HK Ruokatalo has also reduced the amount of salt in all product categories, and in five years the products have contained altogether over 60 000 kilograms less salt, compared with the numbers in 2007. (HK Ruokatalo 2012.)

The food industry follows trends closely and creates new products based on them, which does not necessarily always please nutrition experts. Several persons mentioned present low carbohydrate diet trend that has indirectly brought new products on the market, such as low-carb bread. Also the consumption of butter and other full-fat dairy products has recently increased so it remains to be seen if we will experience a third round of fat wars.

7.7 Media

The role of the media has often been underestimated in policy making, but the mass media can be considered as an agenda setter. The mass media has influenced and continues to influence Governments' policy agendas and they are able to raise and shape issues and public opinion. Politicians often change their priorities based on issues addressed by media instead of based on evidence of what is in the public interest. As politicians have many sources of information, it is hard to say exactly how much media affects political decision makers, and media sources may be valued differently. The Internet has changed the interaction between citizens and politicians, and the direction of public opinion has become less predictable than before. Many media depend on advertising and they have commercial goals, which may directly influence the content as well. The media may also have various public health campaigns which main objective is to win readers;

hence they can be highly populist. (Buse et al. 2005, p. 75-79.)

The study of Harrabin, Coote, and Allen (2003) showed that the news agendas of the print and broadcast media contained a considerable amount of dramatic stories, crises and scares, rather than issues that statistically have a greater impact on health, such as smoking, obesity, mental health and alcohol misuse. To summarise, diseases with the lowest risk to population health receive the highest level of coverage. To take one example from the UK, the MMR vaccine case (e.g. Godlee, Smith & Marcovitch 2011) is one of the probably most well-known issues regarding public health damages caused by media. Another example is related to dramatic stories and scares; yellow press style declarations what is causing or preventing NCDs. For instance, I found online a “Kill or Cure?” list which is a collection of various claims regarding cancer published in the Daily Mail²⁵. The list could be funny if only it was not true.

My research supports these observations. All the interviewees stated that media definitely have influence, and media was called the fourth estate. The role of media was seen to be extremely important, both in positive and in negative sense. Several respondents commented that however, the use of power seems not always to be responsible. Especially regarding health related articles and news that appear almost daily in several Finnish media, the interviewees were collectively irritated at the content which was described as “nonsense and scientifically false”. Several persons said that media are very short sighted and superficial, they look for scandals and sensational headlines and they want to have drama. To enable all this, they choose people representing opposite opinions to create conflict, they skew research results and cut and connect things which are not necessarily even close to the original research report. One person commented that Finnish media tend to publish great headlines of e.g. findings of communicable diseases which do not present a true public health risk but they totally terrify people. On the other hand, the real risks, such as obesity, alcohol misuse, smoking or type 2 diabetes are usually ignored, because there is no scandal or any “news” and they

²⁵ <http://kill-or-cure.herokuapp.com/>

betes are usually ignored, because there is no scandal or any “news” and they do not sell well enough. One person commented that regarding health and health policy, the good news are no news, only bad news or total nonsense seem to be interesting from media viewpoint.

No one said to have noticed that Finnish media would have an own health policy agenda, although they do take stance on various issues.

Media were said to steer people’s behaviour and they can maintain wrong or one-sided impressions and views on societal phenomena. The view on mental health issues, public healthcare, elderly care and geriatrics were given as an example. For instance, it was said to be ‘fashionable’ to blame public healthcare and to declare that health centres are ‘guessing centres’ [a Finnish wordplay, does not translate very well]. However, a great share of doctors working on the public sector may also have a private practice; the quality should not be very different. Also geriatrics and elderly care were mentioned to suffer from a mirage; although the perception is that “all old people wear nappies and drool in their hospital beds”, in reality only a fraction of retired persons are in hospitals and most “old people” are very lively and functional.

In terms of media, the respondents were very unanimous on several matters. One of them was the influence on political decision makers, especially on Ministers. It was said that for instance, if an editorial takes a negative stance on e.g. an MSAH project or initiative, many decision makers read only the headings and decide immediately that well, apparently that one is not anything they should support. The media was said to steer and control politicians and political parties. One respondent described the path by saying that media advances the agenda. Ministers bring it forward to their respective Ministries, which transmit it to the sector research institutes and other operational level activities. Sometimes the influence on agenda is just temporary, ad hoc even, but it definitely shapes the atmosphere and prerequisite ground for making health policy.

Several persons also mentioned that media's effect on policy making causes bouncing; all the Ministers were said to be ready to jump and run and to change the policy course, depending on which issues and in which tone media introduces them.

Another issue, which appeared several times, was the role of Finnish women's magazines. They were mentioned affecting positively, sharing correct information on nutrition and giving practical advice on cooking and housework. Also e.g. access to birth control and sharing proper contraceptive information were mentioned as examples regarding public health. Women's magazines were mentioned to be an important medium that reaches successfully its target audience.

Health is an increasingly popular topic and new magazines are launched. Health is also an important factor in marketing, several daily papers have more health news than before, and they may also have health-related supplements. This health expansion raises health awareness among people, and especially digital and social media have increased opportunities for searching and sharing information. A few interviewees commented that they feel that people are nowadays much health-savvy than before. This development also changes the understanding of the causality of health; previously, it was believed that the health of an individual is in the hands of a physician or God, but due to the amount of health information available today, people have started to understand that their own choices largely affect their health.

Regarding the views on health journalists, the opinions were slightly divided. Some respondents did not see that there is expertise on health issues among journalists. However, some others commented that although there is no expertise on health policy, and only a little on healthcare policy, there are still some good and professional health journalists in Finland. Regarding political correspondents, no one felt that among them would be health policy experts. One person commented that health policy is addressed if Members of Parliament argue over alcohol policy, but it is not worth expecting any deeper analysis. In general, magazines were

mentioned to be slightly more professional than daily papers.

Only one name was mentioned as an example of a competent healthcare journalist, namely Marjut Lindberg from Helsingin Sanomat. One respondent commented that while he may often disagree with Lindberg, due to different ideological views, Lindberg can still be called the best expert on healthcare policy among Finnish journalists.

Especially the rise of social media is challenging to the old institutions; also wrong and flawed information spreads fast. On the one hand, social media can function as a necessary platform for peer support and sharing experiences and information, but the same thing challenges health professionals, decision makers, and also the more traditional media. Therefore, from institutions' point of view, cooperation and interaction with media were seen to be highly important, especially crisis management and sharing the right information to journalists.

Finally, health and health policy are quite challenging fields for a journalist; one needs to follow various topics from pharmaceutical innovations and nutrition to disease prevention and modern technology. To ease the pain, Finnish health journalists have an organization, Health Journalists, which connects journalists who follow medicine, health care and health policy. It organizes seminars, educational visits and training. (Terveystoimittajat ry 2012)

7.8 Parliament of Finland and political parties

The Parliament and political parties are combined in one chapter because in my research, these two were very often discussed together and understood depending on each other.

The traditional Finnish governance model has been state-centric. Until the end of the 1980s, the three focal institutional pillars were a strong President, the Government and labour market organisations. In the 1990s, the Finnish political governance changed dramatically; the role of the President was diminished and the

Government became the centre of attention. The focus of politics was transferred towards political parties and the Parliament. In 2000, the new constitution came into force and it strengthened parliamentarism and the position of the Parliament. However, while the governance changed officially and the constitution affected the relations between the highest state bodies, this reform did not incorporate the unofficial institutional structures and corporatist consensus. The world changed significantly in the 1990s which affected Finland as well, as has been reported earlier in this study. Indirectly, global markets and competition have challenged Finnish parliamentarism as well, and from institutional viewpoint, the Government is in a key position. (Tiihonen 2006; Finnish parliamentarism also in Nousiainen 2008.)

Jorma Kalela (2008) writes that representative democracy in Finland does not work the way it should, and the everyday troubles of an ordinary citizen and the values on the agenda of the political decision makers do not meet. According to the prevailing perception of politics, it is defined through institutions; politics is done in the Government, in the Parliament, in municipal Councils and in political parties. Although very often citizens are accused for not using their right to vote or to participate, Kalela (*ibid.*, p. 202) comments that for some reason it has not been considered as an option that perhaps citizens do not have channels to influence the content of politics. Their role seems to be in choosing between already decided options and evaluating policy choices afterwards. According to Kalela (*ibid.*), also in politics, citizens are seen as consumers who buy ready-made commodities. He comments (*ibid.*, p. 222) that for political parties, citizens seem to be objects of actions and a resource instead of subjects. On the other hand, citizens probably feel as close to political parties as they are to their local shopping mall.

There is no public discussion of political priorities or urgencies or which questions are taken on the governmental agenda, although democracy would require it. Regarding discourse, Kalela also writes (*ibid.*, p. 213-6) about the imperative of economy and says that it seems that “managerial language” defines the field so that the objects of different policies are discussed only in predefined frameworks.

In the Finnish political system, the function of Members of Parliament (MP) is to represent and articulate the needs and wishes of their voters. Kalela writes (*ibid.*, p. 217), that based on the previous Government Programmes, MPs have not succeeded very well in their mission. However, Kalela emphasises that the problem lies in the system and in the operational environment and the same would apply regardless of the ruling or opposition parties. He writes that already in the 1990s, non-politics became the political ideal; the political environment changed being less dependent on Finnish domestic actions and the market overtook the state in political order of importance. Likewise, the corporatist system and apolitical nature of governmental policy has strengthened the rubber stamp role of the Parliament. The Governments have lately ruled the whole four years so the role of Government Programme has increased. At present, a single Government party MP has only very little influence and chance to get his or her issue on Government agenda, and the opposition MP even less so. (Kalela 2008.)

In my research, all the respondents agreed on the role of the Parliament in health policy making; it was said to be non-existent or very weak. The same applied to political parties, although many interviewees continued that in their opinion, “they should have some role” or “if they do not have a role, who does?”.

Formally, the Parliament represents the Finnish citizens and it approves the Government Programme. In fact, it does not have any chance to decide in a few weeks time after the election, which issues are and will be important and should be discussed. Several respondents mentioned the increased role of the Government Programme and they said that the hands of the Parliament seem to be tied. Also Ministers were seen to be powerless to bring any new initiatives on the agenda. Regarding MPs, it was believed that the group discipline is so strict that there is no room for individual MPs to advance their own ideas. Some interviewees commented that the problem lies also partly in the Parliament itself; even when MPs are invited to health policy seminars, working groups, hearings or meetings, they very rarely come. There are usually a couple of active MPs who are genuinely interested in health issues but more often the MPs are not interested, or at least they will not participate.

Interestingly, however, the Parliament was mentioned to be health friendlier compared with the Government; one respondent speculated that perhaps MPs are closer to the citizens and the health field and know more about their worries than Ministers or Ministries.

The Government gives the Social and Health Review every four years to the Parliament, but it is mainly discussed only in the Social Affairs and Health Committee, not in the plenary session. One person commented that even if the Committee discusses health policy, no ideological value choices are made there. Therefore, it was proposed that this review would have a more significant role if it was taken to the plenary session to be debated, such as e.g. the Government's Security and Defence Policy Reports. The role of the Parliament was seen to be limited to budgeting and to some extent to legislation and the EU affairs. In other words, the Parliament decides how much money will be allocated to health services, they pass laws, perhaps changing some minor details, and process EU related issues in the Grand Committee. One person commented that it is good to have the Parliament involved in the EU affairs and to subject them to a large group of people, considering the constantly growing importance of the EU in health policy.

One aspect in the Government – Parliament relation is the effect of political change and elections. On the one hand, continuity and consensus was appreciated and it was said that issues and policies are advanced regardless of which parties are ruling. On the other hand, the Prime Minister is the key person in determining the code of conduct and how the Parliament and the Government will work together; some Prime Ministers have been more active in bringing issues to the Parliament to be discussed, while some others have carefully selected the, from the Government's viewpoint, most essential ones.

When discussing political parties, several respondents commented that compared with the situation in the 1960s, 1970s, and 1980s, current parties do not have any vision on health policy nor health political platforms. The big picture was mentioned to be lost and one respondent summarised many others' thoughts by saying that political parties advance issues only case by case, depending on the current trend or what the media says. Because political parties do not have own political

views on health policy, it is left to NGOs, experts and lobbyists. This absence of health political views may cause lack of political commitment, and it will lead into situations, where some policies and objectives are announced in ministerial and parliamentary speeches, but executed policies will lead to other results. One example of this kind of contradiction is lowering alcohol tax in 2004, which led to increase in alcohol-positive sudden deaths.

Many respondents were hoping that politics would return to politics; political ideology was mentioned to have disappeared and political policy making was described to have become technocratic and pragmatic. The consensus on the objectives of Finnish health policy origins from the 1960s and the 1970s; the other parties were said to have implemented the health policy of the Social Democratic Party (SDP). Currently, it seems that political parties do not consider health as a very important issue so that it would rise very high on party agenda. Some institutions have or have had politically appointed directors and the posts have traditionally belonged to certain parties. One example is Kela, The Social Insurance Institution of Finland, which has 'always' been led by a Centre Party representative.

All the parties were said to support municipal and public health services and to find them important. Especially the SDP and other left-wing parties prioritise public service production, while the National Coalition Party was mentioned to emphasise private sector and patients' freedom to choose their service producers. The Centre Party was mentioned to concentrate on regional policy and municipalities. Health service production and priorities between public and private were seen as the only ideologically dividing issue, and actually, the only health-related issue that the parties discuss or argue about. Therefore, it seems that also in many political parties health policy may be understood as healthcare policy.

Many respondents questioned the health expertise in party machineries; the larger parties may have resources to hire, or at least to consult, professionals but especially smaller parties' chances to cover the health policy field caused scepticism. It is worth noting, though, that there are medical professions represented among MPs, in the party headquarters and also at the municipal level, but naturally the

earlier discussion on professions apply.

"(--) [At the moment], there are probably only two individuals in our political parties, I mean both MPs and the ministerial level, who understand this [healthcare/health policy] system. (--)" R4

" (--) Someone may take child and youth health as his or her election theme, but it does not carry us very far if they don't have anything else to say than "the health of children and young people is important". After that, a platform is still needed... I mean, it is somehow so hollow, so to speak, the argumentation, from the viewpoint of expertise or those acts and statements. Whatever is the political argumentation. (--)" R8

When the political consensus was discussed, one interviewee speculated that as most of the health professionals working in the public sector service system probably vote for the National Coalition Party, it does not want to jeopardise their support by suggesting significant changes. However, as the example from the US and President Obama's initiative for the Universal Health Care shows, health is still considered political and there are also global attempts to increase public health care to decrease socioeconomic differences in health.

8. CASE: THE GOVERNMENT RESOLUTION ON THE HEALTH 2015 PUBLIC HEALTH PROGRAMME (HEALTH 2015)

This chapter addresses my case, Health 2015 (Ministry of Social Affairs and Health 2001), and it is based on my interviews and available documents (see also Chapter 2 and Appendix 3). The programme outlines the targets for Finland's national health policy for 2001-2015 and the main focus of Health 2015 is on health promotion. Health 2015 was prepared by the Advisory Board for Public Health in 1997-2001. The document is structured around two concepts, "settings of everyday life" (toimintakenttä) and "course of life" (elämäntulkku). Health 2015 presents 8 public health targets, and there are also 36 statements that concern the lines of action by the Government.

Before opening the Health 2015 actors and process, I will begin with a short introduction to use of programmes in Finnish health policy making. To avoid confusion, I will use 'Health 2015' as a name from the beginning, although it was decided only in the end of the process.

8.1 Programme-based policy making in Finland

In terms of health promotion, programmes have been considered both positive and negative. On the positive side is the process, which was in my interviews compared to political platform process; it connects several individuals and organisations with various backgrounds, which brings new ideas and fresh thinking into the process. In addition, even if the programme or policy would not be very successful per se, these people take ideas and new information back to their organisations and may advance health promotion in some way despite the programme failure. It was also mentioned, that Ministries and civil servants do not necessarily have the most recent information "from the field" so horizontal and extensive working groups ensure that the most relevant and up-to-date information is available. Therefore, programmes are seen as a way of gathering all available expert knowledge in one document. An inclusive representation of actors will also help in engaging the stakeholders in implementation.

On the negative side, lack of implementation and scarce resources are very typical for Finnish policy programmes (also Berg 2012; Heinämäki 2012; Sihto 1997) although it is not just a Finnish problem, as I mentioned in Chapter 5.5. The completion of a programme is considered as the “finish” and usually no thought has been put to implementation. On the contrary, the following programme project is usually already taking all the resources and the brand new programme document will be shelved, next to all previous ones. Very often also indicators for monitoring and accountable actors are missing. Programmes may remain unknown, so they are not implemented. Programmes are often overlapping and even contradictory, they are made for a short term and they may contain “old stuff in a new package”.

The principal problem from an institutional viewpoint is that if health promotion and health policy are regarded as a field that can be covered and advanced by projects and programmes, there will not necessarily be political and governmental motivation or interest to invest in sustainable structures and human resources that, especially in primary health care, are the basis for good population health.

Almost all respondents said that if they should name one event or a turning point for the beginning of this programme-led era, it would be the administrative reform in 1993. Switching from state-centric normative steering system to information steering was considered as pivotal; the tools in information steering system are programmes and projects. After 1993, the municipalities could not be controlled by other means than legislation, and as one respondent summarised the situation *“if you can’t make a law, you will make a programme”*. Programmes were applied first in policy making, and when they did not work, projects together with funding were introduced into administrative toolbox. The abundance of programmes was called “project religion” and it was said to have even increased in the 2000s. (see Chapter 4.3). Also the EU has affected programme and project enthusiasm, but its influence has been greater only recently.

While the 1993 reform can be regarded the most significant event in programme-based policy making, programmes have existed already since the 1970s. The 1960s, the 1970s, and even the 1980s, were periods of healthcare structure de-

velopment, as has been reported in Chapter 6.2. Community health centres, new legislation and increased resources for primary health care were on the agenda. However, programmes and projects were borne at the side of structural reforms and one interviewee commented that

“(--) People started to think that as long as we have these programmes and content, we will do fine; our team on the field can play as long as there is a manager who tells them how - there is no need for training. (--)” R1

This quote also reflects the, also currently prevailing, although controversial, belief in the ruling competence and expertise of local actors and professionals.

The earliest programmes seem to be published by Sitra, the Finnish Innovation Fund which was founded in 1967. Sitra had seven health-related research and treatment programmes in the 1970s. The most renowned Finnish public health project, the North Karelia Project, launched in 1972, was mentioned as one specific example of that time to promote project-led health policy. Although this project has many indisputable advantages and it is unique also in a global scale, in my study North Karelia Project was seen also for its part to have enabled the basic idea that public health problems and health promotion are something that may be solved and advanced through projects, regardless of infrastructure.

In general, there were also some foreign influences affecting Finnish policy making and administration at that time. One interviewee was recollecting that when President Mauno Koivisto was elected as the Chairman of the Board for the Bank of Finland, he adopted a concept of five-year planning that was said to originate from the Dutch economist Jan Tinbergen.

One important normative state-centric steering system was the national plan for organising social and health care (VALSU). VALSU was originally decreed in the Public Health Act in 1972 and they were steering instruments for health care, and later also for social sector and environmental protection, approved by the Government. VALSUs were made yearly, and the first VALSU covered years 1972-

1976 and the last one 1999-2002. When VALSU system was abolished in 1998, the Target and Action Plan for Social Welfare and Health Care (TATO) followed it in 1999. The first TATO covered years 2000-2003. TATO, on the other hand, was followed by National Development Programme for Social Welfare and Health Care (KASTE). KASTE was renewed in February 2012 and it will extend to year 2015.

The National Board of Health was responsible for VALSU system until the Board was abolished in 1991 and since then, the MSAH has been responsible for all these national plans.

One reason behind programme-based policy making may be in NPM-related changes, especially the disappearance of political committees. One interviewee mentioned that he sees the change in a wider context, not just as the 1993 reform, because when there were no political committees, they needed to be replaced by something which usually meant projects. VALSUs were not the only programmes carried out by the National Board of Health and the MSAH, and both institutions were mentioned to have several programmes already before 1993.

The amount of programmes and their tendency to overlap may be explained by experiences of various actors in health policy field; there are several operators with various interests and working groups and programmes may be the easy way out. Not necessarily the most efficient or even the most reasonable, but that is the way things have “always” been done.

8.2 Health 2015 and other policy programmes

As was listed in Chapter 6.2., there are dozens and perhaps hundreds of health-related programmes in Finland. In the beginning of Health 2015 process, Mikko Kautto and Seppo Koskinen reviewed the contemporary public health programmes and they concluded that it is not possible to have a comprehensive and up-to-date understanding of all national health promotion programmes (D12, D18). They noticed that the objectives were usually expressed at a very general level and the executors were mainly authorities and public administration. They also

found that the programmes rarely defined the accountable actors. The programmes were written in passive voice, they were partly overlapping and hardly ever were there references to programme evaluation. Kautto and Koskinen noticed that significantly many programmes were planned to end in 2000 so they estimated that making Health 2015 programme, it was then called “Health for all in the 21st century”, would be a good opportunity to create new viewpoints for future health promotion programmes.

Especially during the era of the National Board of Health, public health programmes used to be disease-oriented and many NGOs still have their own programmes. However, already before Health 2015 process, but also in Kautto’s and Koskinen’s programme review, it was noticed that most chronic diseases and NCDs have in fact the same risk factors, e.g. smoking, alcohol, unhealthy diet, lack of exercise and indirectly also obesity, high blood pressure and high cholesterol levels. Therefore, instead of writing the same risk factors over and over again for separate disease-based programmes, the mindset was intentionally changed away from diseases into health arenas and the course of life.

Health 2015 followed the two earlier national public health programmes:

- Health for all by the year 2000. The Finnish national strategy. (Sosiaali- ja terveysministeriö 1986)
- Health for all by the year 2000. Revised strategy for co-operation. (Ministry of Social Affairs and Health 1993)

In international context, it was linked to the WHO Health21 programme (WHO European Regional Office, 1999).

As I wrote in Chapter 6.2, there is no database which would show the connection between various programmes. Since Health 2015, there have been several projects and programmes and as Health 2015 is still in force and it is a long-term public health programme, presumably they should be connected to Health 2015. For instance, the MSAH requires that health promotion projects are clearly con-

nected to Health 2015 as well as other health programmes, before it grants funding.

8.3 Preparatory process

First, I will present some general observations and then proceed to participants, objectives, resources, communication, structure, content, and preparatory schedule in more detail. However, due to characteristics of a process, these sections are partly overlapping.

8.3.1 Some general observations

The Health 2015 process started in the 1997 and the programme was published in May, 2001. During these four years, there were all together three different Ministers of Health and Social Welfare responsible for the programme. They all belonged to different parties which also were quite small. Terttu Huttu-Juntunen (The Left Alliance) held office until April 15, 1999, Eva Biaudet (The Swedish People's Party) served as a Minister in 15.4.1999 - 14.4.2000, and Osmo Soininvaara (The Greens of Finland) served in 14.4.2000 - 19.4.2002. After the parliamentary election in 1999, the parties agreed that Biaudet and Soininvaara would share the portfolio and they were meant to serve in two-years terms. However, due to Biaudet's maternity leave, the terms became 1+2+1.

As the previous chapters have demonstrated, Finnish health policy have been mainly led and initiated by a group of active and dedicated civil servants. It was quite striking that none of the Ministers or other political actors were not even mentioned in any documents that I investigated. Their names appeared only in Act on Public Health Committee (Huttu-Juntunen) and Health 2015 programme book (Soininvaara). Not surprisingly, Health 2015 was also initiated by civil servants. Apparently, it has had political approval, but one cannot say that the initiative would have come from the Minister or that some party or other political decision-maker would have felt fervour of this programme. This lack of political interest or the uncertainty of the existence of political interest appeared in my interviews as well; several persons mentioned that they were often wondering what is

their mandate to prioritising and decision making. They assumed implicitly that there is some political support, but when they had to make decisions on guidelines, actors, priorities or some other issues, they felt that they are somehow responsible for those choices although they had not directly received a political mandate, or at least explicitly communicated political objectives and expectations.

There was no reference to a public health programme in Paavo Lipponen's Government Programme for 1995-1999²⁶. Health policy in general is in a very minor role. In the Lipponen II Government Programme for 1999-2003²⁷, the programme is not mentioned, either.

The common perception was that Health 2015 was made because the previous programme term was ending and Finland needed to have a new programme. The reasoning behind making the programme was partly unclear to even those who were involved, or they said that they had not thought about it, which may indicate that there has not been much discussion from this viewpoint. The Advisory Board for Public Health (also called *Public Health Committee* in some documents) was given the programme work as an assignment (M1, D2, D3), and some respondents commented that they believe that it was just a natural continuum. Instead, to not to have a new programme would have been a significant statement and a prominent policy change. The external WHO evaluation also affected the assignment.

The reasoning was explained for instance as follows: *"the MSAH needs to have a programme, that is why it was made"*, *"the previous programme was evaluated, so it was finished, and we needed a new one"*, *"we hade good experiences of the previous programmes"*, *"we wanted to promote public health"*, *"we needed to prioritise health issues"*, *"it was made just because it had to be made"* and *"at*

²⁶ http://valtioneuvosto.fi/tietoa-valtioneuvostosta/hallitukset/hallitusohjelmat/vanhat/lipponen/Hallitusohjelma_-_Lipponen112834.jsp

²⁷ <http://valtioneuvosto.fi/tietoa-valtioneuvostosta/hallitukset/hallitusohjelmat/vanhat/lipponenII/fi.jsp>

that time, *Finland was a pilot country for WHO so it was important to keep the position*".

Most of the respondents involved in Health 2015 said that the process was extremely hard and laborious. The main difficulty was that there was no full-time ABPH Secretary General or other person responsible for coordinating and organising the programme process. Besides Health 2015, the Advisory Board had also many other tasks. The ABPH part-time secretariat was extremely busy with their own work in the MSAH, in Stakes and in KTL, but the main responsibility for drafting and coordinating the Health 2015 laid still on their shoulders. Out of four secretaries, Merja Saarinen, Seppo Koskinen and Mikko Kautto took on the most work, and Terhi Hermanson's name appeared in the Health 2015 documents only a few times, perhaps due to her other duties (e.g. D45).

In fact, the process seems to have been so stressful, that several respondents said that they feel that they suffer from a kind of blackout regarding that period of time. One person said that a year or two have totally been erased from his memory. The secretariat has been in a crucial role during the first years and they have worked non-paid overtime partly also during the weekends and holidays; in addition to official meetings, they have had several unofficial gatherings and the amount of Health 2015 related emails has been substantial. However, everyone said, unbeknownst to the others, that they found the programme work and the state of Finnish public health so important that they felt that they had to do it.

Many interviewees also commented that although the process was stressful, it was also fun. Most of the civil servants and other ABPH members had been working with each other for a very long time and they knew each other very well. In my interviews, it appeared obvious that they genuinely also like and respect each other. A couple of respondents commented that they have sometimes thought afterwards that perhaps the process, ABPH, secretariat and experts were even too amicable and a little discord might have been good. On the other hand, some people added that because the process was so hard anyway, they are glad that at least the people involved got along so well.

The enthusiasm and energy was highly visible also in the minutes. The discussion on the content, priorities, actors, schedule and structure has been really active and lively, which caused both information richness and disjointedness. The content and structure of Health 2015 changed a few times during the process, even when something had been prepared already for a long time (e.g. M2, M3, M7, M12, M13, M14, M17, M19, M25, M30, M32, D33). In addition, ABPH sometimes changed priorities after the secretariat or divisions had prepared a proposal based on the discussion in the last ABPH meeting, and the seminars and expert statements influenced the discussion, as well.

There was already from the beginning a consensus on documentation, and ABPH wished that all the seminars, meetings, hearings and other events would be carefully documented, because that material can be used in “field work” already before the programme is ready (M25). There was also discussion on editing these partial documents and thematic entities of programme chapters into various handbooks.

In the beginning of the process, ABPH was aware of the parliamentary election in 1999. It found necessary that there is interaction with political parties during the process at various stages (M12, M25, M33, M35, D10). Especially influencing in the prospective Government Programme was found important. Also relations and the importance of media and industry was discussed several times during the process (e.g. M7, M11, M15, M16, M30, M35, M39, M42, D10). The plan was to follow the previous Health for All programme procedure that was found appropriate; the new programme would be subjected first to the Government approval and after that, it would be sent to the Parliament for a plenary discussion (M12). ABPH did not, however, have briefings with political parties and due to delay in schedule, the Advisory Board did not specially inform parties before negotiations on Government Programme. Some respondents thought that perhaps the MSAH civil servants have met with politicians, but no one remembered having organised Health 2015 related meetings. In spite of plans, Health 2015 was not approved by the Parliament and it was not brought into plenary session, either. However, the programme booklet has been sent to every MP for information in 2001.

Besides parliamentary election, ABPH took notice of other events affecting its schedule and perhaps also the content of Health 2015: the new programmes of global WHO and WHO Europe, the Public Health Programme of the EU, and the Finnish EU Presidency, all in 1999 (e.g. M25). There was a parallel programme process in Sweden at the same time (Nationella folkhälsokommittéen 2000; D56) and ABPH followed it closely trying to receive all the Swedish material, as well.

The length of the programme period and the name were undecided for quite a long time. At first, the programme was planned to cover 10-20 years (e.g. M10), and in October 1999 the timeframe seems to have settled for 15 years (M12). The name was discussed in several occasions, and ABPH saw that a good and appealing name could increase the public interest. ABPH also discussed the international critique that WHO was encountering and the Advisory Board was pondering if it is good that Finland connects the national programme or even name to WHO or the context of Health for All by 21st Century. However, there were several alternatives, such as "Health for All", "Health Together", "Health for All Together", "Our Common Health 2000", "TK21", "Terve! 2000" [translates the best as "Salve! 2000"] but the document was mainly called TK21 or Terveyttä kaikille 21 (shortened from Finnish, meaning Health for all by the 21st century). (E.g. M3, M10, M16, M20, M25.) There was no joint decision over the name written explicitly in the minutes, and several interviewees said that in their opinion, the name was decided in the MSAH on the homestretch of the project and they mentioned Jarkko Eskola as the potential inventor of Health 2015.

8.3.2 Participants

The basic actor behind Health 2015 was the Advisory Board for Public Health. The first ABPH was appointed in March 1997²⁸ and the assignments of ABPH are as follows:

²⁸ Asetus kansanterveyden neuvottelukunnasta 67/1997; HE 230/1996 vp; StVM 37/1996 vp

- to monitor the development of public health and implementation of health policy
- to develop national health policy and promote health promotion cooperation and interaction among various administrative fields, organisations and other stakeholders
- to prepare, in cooperation with experts, disease-oriented and problem-based health programmes and follow their implementation
- to execute other tasks commissioned by the MSAH

The Government appoints ABPH following the proposal of the MSAH. The term is three years and the members need to represent diverse public health expertise and those authorities which are central to health promotion. ABPH has to be regionally and linguistically representative. The first ABPH served in 1997-2000 and the second in 2000-2002. The members, their deputies and expert representatives are listed in Appendix 4.

The Social Affairs and Health Committee of the Parliament gave a statement to the Government's proposal and it proposed (StVM 37/1996 vp) that

" (--) At the same time, when the Social Affairs and Health Committee supports establishing the Advisory Board for Public Health, it finds important that there is also parliamentary representation in the Advisory Board. (--) "

However, there are no parliamentary representatives in the ABPH.

The role of ABPH was partly questioned in my interviews, especially regarding its function and resources. Similar criticism was also presented in the report of Muurinen, Perttilä, and Ståhl (2008) and many respondents saw that ABPH is just a "tea party" which does not have true influence, partly due to lack of resources. On the other hand, the importance was seen to be exactly in enabling discussion, and it was mentioned that it is a good platform for hearing what other Ministries and stakeholders are doing and to enable coordination on health-related matters.

Some respondents saw that ABPH is in a wrong place in terms of administration; the MSAH does not have power over other ministries so HiAP cannot be fully executed.

WHO criticised in the external evaluation in 1991, that the executive committee and the preparatory process for the Health for All by the Year 2000 programme was not representative enough (World Health Organization 1991). Therefore, from the beginning ABPH found it important that the new programme will take the criticism seriously (M2). In addition to a more representative preparatory body, there were several working seminars and meetings, and while there are no exact numbers, names or organisations available, the interviewees estimated that altogether at least one thousand experts and public health enthusiasts were involved. Some of the seminars were open to public, some of them were by invitation only. The dichotomy of enthusiasm and realities was seen, when the seminars were planned. The Advisory Board was eager to have several kinds of seminars and activities around the programme, but e.g. Tapani Melkas was worried already in December 1997 that there may be too many seminars, taking into consideration the amount of work which is needed for preparation and documentation (M4). Based on my interviews, he was not alone in his worry, either. The seminars are listed in Appendix 5

Besides seminars, health professionals and other experts were also involved in the form of requested feedback. ABPH approached various people during the drafting process, and for instance, in the August 1998, the preliminary chapters were sent to 3-4 experts each for commentary and new ideas (M8, D29). In December 1999, a 114-page programme draft was submitted for statements (D48). I was not able to find any criterion for selecting these professionals or recipients of statement requests, but I was told that the MSAH has a permanent contact list which will be supplemented depending on the issue. There was one document suggesting that the statement request may have been sent to all those who have been involved in preparing material for programme chapters (M13). By deadline, the ABPH received comments from 47 stakeholders, of which 26 were either an organisation, an institution, a corporation, or a governmental bureau. The other

statements, 21, were signed by private persons, mostly social and health care professionals. I also found some other statements which are not listed in the summary (D52), and I have listed all contributors in Appendix 6.

Most of the general preparatory work was done during the term of the first ABPH; during the term of the second assembly, the programme was mainly processed in the MSAH.

ABPH has the right to set up divisions (jaosto) and during the first ABPH there were three divisions involved in Health 2015: Programme Division (ohjelma-jaosto), Working Division (työjaosto) and Implementation Division (toimeenpano-jaosto). The delegations and their members are listed in Appedix 4. The divisions were smaller in size and in addition to secretariat, they were preparing and processing the material and ideas for ABPH meetings. The main Advisory Board was, and still is, quite large so it would have been quite difficult to process documents and ideas there. In practice, the divisions served as preparatory bodies for the main Advisory Board and there were also some working groups under divisions.

Especially in the beginning, the responsibilities and tasks of divisions raised discussion among division members, and they were aware of their role in Health 2015 process but also in supervising the earlier programmes, organising seminars and taking care of other duties which were given to ABPH. In general, the function and role of ABPH was seen very important already from the beginning and ABPH was also asked to produce strong statements regarding actual health issues. The long-span characteristics of their work was emphasised and especially in the beginning. (M2, M15.) ABPH and delegations discussed quite often what they should do and more importantly, what they are able to do in terms of authority.

Towards the end of Health 2015 process, Professor Juhani Lehto became one of the key persons regarding the final version. Due to schedule and resource problems, ABPH commissioned a draft from him in February 2000 (D50, D51, D53). Tapani Melkas and his superior Jarkko Eskola processed this document further in the MSAH (D55).

Some remarks regarding other ABPH members. Markku Lehto, the Chief of Staff and Chairman for ABPH was not involved in the grassroot work, because, first of all, he had a Ministry to run and he also believed the Department Heads, Jarkko Eskola and Kimmo Leppo, as well as one of the most central civil servants, Tapani Melkas, and the secretariat were capable of conducting the process. As a Chairperson, he participated in the meetings and discussions, but he did not interfere with the work of secretariat or divisions. Therefore, he may have been slightly detached from the process. Some interviewees commented that Markku Lehto, as a social scientist representing the social policy “party” of the MSAH, may also have had different opinions on the content and structure of Health 2015 than those ABPH members with health and medicine background. He was also described as academic thinker, and some people experienced his approach sometimes too theoretical and philosophical.

One of the main Finnish health policy advocates, Kimmo Leppo, was not as involved in the process as one may have expected, either. First of all, he was member in the WHO Executive Board in 1994-1997, which he experienced as a demanding period of time. Health 2015 belonged under the Department of Preventive Social and Health Policy, but Leppo was running the neighbouring Social and Healthcare Service Department of the MSAH, so he was concentrating mainly on his department. In 1999 he was invited to WHO to work on the International Tobacco Act FCTC (also in Leppo 2010b, p. 40) and after that, he also was away from the MSAH for one year, August 2000 – August 2001, when he was working for WHO in Geneva.

There were also other changes in the MSAH staff. Merja Saarinen, the MSAH key person in the secretariat took off duty as of August 2000. She was replaced in ABPH secretariat by Taru Mikkola (at present: Koivisto) who came to the MSAH from Stakes in January 2001.

In general, the composition of ABPH was decided by the Government. Formally by the Minister, but she mainly followed the proposal of the MSAH civil servants. The interviewees considered the Advisory Board to have been quite functional, but one person mentioned that perhaps there should have been also younger par-

ticipants involved, such as the think tank Demos²⁹. The absence of younger health actors was also mentioned in the minutes (M4). In addition, several respondents said that they had put quite a lot of thought into the role of media and industry, and in their opinion, both stakeholders should have perhaps been more involved in the process, especially from the commitment viewpoint. Now their role was mainly limited to two seminars.

8.3.3 Objectives

The respondents were partly unsure what kind of document the Advisory Board for Public Health (ABPH) was actually supposed to produce, and the objective was described as “to create a programme”, “to draft an action plan”. It seems, however, that ABPH was working on a programme document which would be parallel to the new WHO programme (M7, M8). One respondent commented that he has never heard anyone in public administration to discuss policy analysis and based on the minutes and other documents, it seems that this kind of theoretical viewpoint was not discussed regarding this process, either. In the minutes, Health 2015 was called “programme document” and the general discourse included “programme work” and “programme process”, but the understanding of a programme may not have been totally congruent among the participants. The secretariat and some divisions have discussed the attributes of a programme also from policy analysis point of view, but these discussions have mainly been private and between only two, three people. This lack of a common, explicit goal and understanding was visible in the documents and while there were demands for prioritising (e.g. M12, M17, M28), it seems that the discussion tended to meander and in almost every meeting there were new ideas, content and viewpoints that the participants wanted to include in the programme.

Especially the MSAH representatives saw that the programme should be short and compact and its function should be to draft the main policy lines and objectives for the Finnish health policy and also define the responsibilities for relevant stakeholders. It is interesting, however, that the opinion about the MSAH’s authority

²⁹ <http://demos.fi/english>

over other stakeholders was divided among the civil servants. For instance, the Revised Strategy from 1993, and also the current KASTE programme specifies the actors and their responsibilities, but some of the interviewees saw that the MSAH has no authority over municipalities, other ministries, NGOs or other stakeholders. Therefore, they said that in their opinion, Health 2015 could not specify the responsible parties and instead it emphasises the voluntary nature of health promotion, although encouraging all actors to take part in it (see Ministry of Social Affairs and Health 2001, p. 27).

8.3.4 Resources and communication

ABPH did not have any extensive budget for Health 2015 and lack of resources was mentioned in all interviews. ABPH would have wanted to have someone to coordinate the programme full-time, but apparently the MSAH, Stakes or KTL did not have funds for that (M13). There were also differing opinions on whether it would have been the responsibility of the MSAH or sector research institutes to appoint someone for the task full time. The lack of resources was discussed several times, and people were also concerned that there will not be enough financial support for the implementation (e.g. M30, M40, D45).

Besides editing work from Professor Juhani Lehto, ABPH was also able to commission a municipal health promotion strategy handbook, produced by Kuntakoulutus Oy. The work was planned to start in the spring 1998, involving 5-6 municipalities and 2-3 participants from each. The handbook was meant to be ready in November 1998. (M40, D23, D47.)

ABPH argued that the credibility of Health 2015 suffers if ABPH is trying to do long-term national health policy without a full-time Secretary General (e.g. M4, M13). Nevertheless, the Chairman Markku Lehto stated that there is no funding for a full-time official (M13). It was confirmed in my interviews as well that if the MSAH would have hired someone for ABPH, they should have done it to the detriment of some other position. The MSAH would have needed more staff also for the Finnish EU Presidency in 1999 and the budget was still very tight due to the recession.

When the first ABPH was finishing its term, Vappu Taipale suggested that the last will of first Advisory Board could be for MSAH to appoint a full-time Secretary General (M13). However, the secretarial tasks are still run as part of other administrative functions.

Regarding communication and marketing, ABPH would have wanted to have professional assistance to help with editing and promoting the programme, and communicating with media. The need was discussed in several meetings (M10, M19, M28). The contemporary Press and Communication Department with the MSAH was very small, and several respondents mentioned that it would not have been worth asking for their help. Especially, as the process gradually started to become very arduous and ABPH was drowning in raw material, the Advisory Board was hoping to have someone to help them with standardising and editing the large volume of text. It was mentioned that the text should be clear and understandable for also those who are not health professionals; the content should be easily accessed by various actor groups (M10, M13).

ABPH found it important that the preparatory process is transparent and in the spring 1998, the Advisory Board discussed e.g. having an up-to-date process description on the MSAH website to enable comments from citizens and various communities during the process. (M7.)

8.3.5 Structure, content, and preparatory schedule

To write about Health 2015 from this viewpoint is quite tricky, because the plans and objectives seem to have changed a few times during those four years that were used for processing the document. Alternatively, referring to my discussion on objectives, various participants may have had a slightly different opinion on what kind of a document ABPH was meant to produce. I also planned to create this chapter in chronological order, but as the schedules were changing all the time and they needed to be constantly revised, I did not find that practical. Therefore, it may be good to know that the original plan was to finish the programme in the beginning of 2000, just before the first Advisory Board would end its term. The first drafts should have been ready and approved by the end of 1998 and by

the beginning of the 1999, but eventually the first whole draft was submitted for statements in December 1999 and Health 2015 was published in May 2001. I will, therefore, report some events in consecutive order but some issues are addressed thematic.

ABPH was unanimous from the beginning that it wants to learn from previous processes. As I have mentioned above, the criticism from WHO was taken seriously and ABPH also organised a seminar on TK2000 [Health for All by the Year 2000] programme in January 1998 to give the stakeholders and other interested people an opportunity to advice the Advisory Board (D17). ABPH saw that it is important to create a good programme, without hurrying, and in the spring 1999 it summarised its central objective; to make everyone see their possibilities for health promotion and to encourage them to act on these possibilities (M12).

The main concepts, 'settings of everyday life' and 'course of life' were agreed on already in the beginning of the process (M1, M9, D10). ABPH discussed these and other mainstream themes, such as equality of health, promoting functional capacity and life control quite extensively. Life control was eventually questioned as a suitable theme in public health programme, because life cannot necessarily be controlled (M16, M25).

At first, in 1997, the Advisory Board was beginning to produce a single document. During the autumn 1997 and the spring 1998, ABPH and its divisions discussed various themes, priorities and viewpoints that should be included or considered in the programme. Some themes and topics were repeated in several meetings.

Instead of giving a chronological and somewhat incoherent description, I will present a summary of the most central notions, based on the minutes listed in Appendix 3. The order does not imply importance or frequency, but this list is merely an overview on the vivid and active discussion:

- importance of municipalities; not just boards of health, municipal councils or municipal boards, but also other levels – reference to a research which showed that most of the decisions are done elsewhere than in decision making bodies

- differences between different actor groups and stakeholders, e.g. municipalities and NGOs
- aging population; policy indicators should apply also to population over 65 years, not just younger people, as most health problems will be accumulating in that population group
- securing the access to primary healthcare services
- growing social disparities in health; conflict between realities and health policy objectives – which ones should be changed?
- customer viewpoint in health care
- activating the citizens; working bottom up instead of top down
- activating the business and industry sector; recognising and communicating the connection between health, welfare and economic development
- the role of education, research and in-service training is very important; investigation of which areas need more research and information
- asthma, allergy, musculoskeletal disorders, chronic diseases, cancers, mental health
- the effects of long-term and mass unemployment on health
- growing alcohol and drug problem; the restrictive influence of international organisations, e.g. the EU on national control; the negative trends in youth health behaviour
- intersectorality in public health programmes; the Finnish health policy expertise may lay on too narrow shoulders
- changes in population health will take a long time
- the importance of identifying the obstacles for successful implementation of policy programmes
- recognising two health cultures; those of experts and of laypersons; these groups also see causalities in health differently
- the role and influence of media; in general, as opinion leader, as a middleman and filter for research, as a stakeholder
- in terms of health promotion, the Health 2015 programme process may be more important than the document or its content
- ad hoc taskforces are a better option than a long-term assemblies; expertise is more important than representativeness

- committing stakeholders, creating incentives and sanctions; a carefully planned strategy is needed for committing media and industry in health promotion
- the importance of connecting the new programme to the already existing projects and operations
- prioritising, resources, consideration for how good ideas can be transformed into action
- a common vision is important; is created through participation and seminars

Quantitative health targets, their advantages and disadvantages were discussed in several occasions and the opinions were divided, some persons even changed their minds. Traditionally, Finland has supported qualitative process targets instead of quantitative targets, but it was discussed if Health 2015 should include those, too. Melkas and Koskinen even participated in an international conference on health targets in 1999, to update ABPH on the current policies and trends. The Advisory Board discussed the targets and their prerequisites, and while there was a common understanding that Health 2015 must be based on scientific evidence and it should be an evidence-based policy paper, it was emphasised that it does not mean only quantitative targets. It was mentioned that if there is a numeral target for e.g. disorder or accident reduction, it includes an implicit acceptance of certain amount of events. This was regarded as one of the disadvantages. Eventually, however, there are quantitative targets in the Health 2015. (E.g. M12, M19, M22.)

As the process went on, in the spring 1998, ABPH decided to produce one compact programme and to have several appendices, such as Government's report regarding the population's state of welfare and health, the municipal strategy handbook and other documents (M7, D25, D26). The structure for the programme document started to develop, and I have attached one example of the basic framework from April 1998 as Appendix 7. The structure was updated and modified, some chapters were removed and changed order, but the general idea stayed the same until the end of 1999.

In October 1998, ABPH named a person(s) in charge for each chapter, and they were processing their respective chapters further (D33). The document begun to progress through thematic seminars which were parallel to the table of contents. Besides seminars, there were external experts who were asked to comment the chapters and text sections were also discussed in ABPH meetings. Ultimately, there were an extensive number of drafts of each chapter, differing slightly from each other in style, structure and size.

It is visible in the minutes, but I was also able to confirm it in my interviews, that as the amount of pages started to grow, it became difficult to the MSAH to commit politically in the content and priorities that seemed to appear in the chapter drafts. Therefore, e.g. in November 1998, it was decided that in the resolution on Health 2015, ABPH or the MSAH will not commit to the “side products”, referring possible handbooks and other documents, but they will be published in some other forums, which remained unidentified (M32).

In May 1999, there were an open seminar on Health 2015 and the chapters were processed further (D44, D45).

In October 1999 (M12), ABPH agreed that it will create two complementary documents, which structure will be similar:

- 1) a compact, an approximately 20-page normative programme book that will be approved by ABPH and subjected to the Government and to the Parliament for plenary discussion; general in nature, drafting the main guidelines
- 2) a background document that will be compiled of the already existing and processed material; it will be an action plan and contains a consecutive plan, when something is supposed to be done

ABPH also started to understand that they will not finish the process on time and it stated that the most important thing is to produce a good programme and it does not matter if the document will be delayed for some months.

The first whole draft, of 114 pages and an explanatory cover letter (D48), was submitted for statements in the end of December 1999. At this point, as has been mentioned, ABPH was able to get external help and it commissioned professor Juhani Lehto to summarise the draft as well as the statements. Juhani Lehto was meant to write a compact document draft that could be developed further in ABPH. He received only structural instructions; the document should be approximately 20 pages, contain quantitative targets and it should be written in the contexts of life course and settlements of everyday life. J. Lehto mentioned in his cover letter in March 2000 that he has done several choices by himself, regarding both content and structure, and as this was just the first draft, he wishes that ABPH will continue to develop the programme (D51).

ABPH saw Juhani Lehto's version meritorious. However, it was seen to emphasise social policy and there should be more content on health care, healthcare infrastructure and how important it is to take care of healthcare personnel. The reasoning was that otherwise it is difficult to make healthcare professionals to become interested in the programme. Also social determinants of health and chronic diseases were seen important and needing more emphasis. (M13.)

In May 2000, Juhani Lehto presented another version (D53), in which the form of the final document is already visible.

- 1) Government resolution; seven chapters from one version in March 2000
- 2) An attachment to Government resolution (additional information to 1, lines of action, action plans, accountable actors)
- 3) Discussion on Health 2015 programme (background document that was processed)

This version was revised in June 2000 (D55). ABPH wished that the programme would be changed into a direction of an action plan, list also short-term operations, define the roles of different stakeholders and what kind of support can be expected from the central administration. Unlike the first Advisory Board, the new

ABPH did not want to emphasise the WHO-based objectives but it wanted to include references to the Constitution of Finland. Also health services, funding of health care, food and nutrition and environment were seen important. (M14.)

Based on the interviews, Juhani Lehto was not very much involved after this, and the document was processed mainly in the black box of the MSAH. I did not have minutes available since June 2000, but the respondents who were involved in the process said consistently that in their opinion, ABPH was not operating much on this issue anymore and the main contributors were Jarkko Eskola and Tapani Melkas. The graphic presentations were said to origin from Minister Soininvaara; he holds licentiate in statistics and he is also well known for his interest for figures and graphs. Health 2015 was signed by Minister Soininvaara and it was finally accepted as a Government resolution in May 2001.

Besides the graphs, other ministerial or political influence is hard to find, probably because the programme was already almost ready when Soininvaara's term begun in April 2000. On the other hand, his predecessor Minister Biaudet held the office for only one year and she was quite busy with the Finnish EU Presidency. Minister Huttu-Juntunen was also busy with the EU, and she did not have a significant role in the process, either.

Regarding Soininvaara, it is worth mentioning that he was also preparing a massive healthcare legislation reform at the same time, launched in the end of the summer 2001 (Soininvaara 2002). Therefore, in the beginning of his ministerial term, he was occupied with healthcare sector.

Besides schedule, one reason for ministerial absence may have been related to persons, and I disregard "personal chemistry" because I do not have any firsthand information. Nonetheless, civil servants may have interpreted the Minister's activity slightly incorrectly and think that he is not interested in preventive health policy but instead is more tilted towards healthcare. On the other hand, Soininvaara may not have been able to communicate his interest sufficiently and hence, he has been left out of the process. I base my argument on the information I received in my interviews, but also Soininvaara himself has described having ex-

perienced prejudice which complicated his activities concerning another societal project that he was involved in. (Soininvaara 2010)

8.4. Policy analysis on Health 2015 document

I analysed Health 2015 policy document using extensive policy programme framework from Cheung, Mirzaei, and Leeder (2010), and the analysis is attached as Appendix 8. The scholars combine policy features from other as well, and for the references, please see the article. This framework was chosen because it is recent, comprehensive, and specifically created for analysing health policy documents. I have also applied a keyword analysis on Health 2015, see Appendices 9. and 10.

The analysis showed that many features, which have been considered to include in proper policy or programme document, were indeed missing. Health 2015 does not define actors, actions, or indicators. Actors and their responsibilities were mentioned very vaguely, which is compatible also with notions of Wismar and Busse (2002; see Chapter 5.5). Health 2015 addresses implementation and evaluation very briefly, and also resources are defined mainly in terms of sharing information, e.g. printing booklets and organising various events on Health 2015. Scientific grounds for policy choices and targets are not discussed and there is no reference to evidence-based policy. With respect to keywords, it is interesting to notice that for instance politics and political parties are not mentioned at all, and e.g. media, which seemed to be in an important role in minutes and interviews, were mentioned only four times.

The interviewees described Health 2015 for instance as follows:

- “it defines long-term strategic guidelines which will be implemented by other, more concrete programmes”
- “in my opinion, it is some kind of a programme; we defined our objectives, who should be involved, and what should be measured”
- “it defines guidelines”

- “it is not a programme, it presents objectives, but it is not in any case a health policy programme”
- “it is a public health programme if that means a programme which defines health policy objectives, but there should have been a separate action plan”
- “it is not a programme, it is a Government’s Resolution”
- “well, it fulfils the administrative criteria for a programme; if WHO asks if we have programme, we can say that indeed we have”
- “it has a couple of programme-ish sections, but it is merely a mess and not a programme in the sense of committing actors or an action plan”

One crucial institutional point seemed to be the difference between “a programme” and “a Government Resolution”. As I wrote already in the beginning of this chapter, there were various views on what in fact is a programme. Also in my interviews several respondents started to reflect the same thing. My conclusion is that the MSAH members were more aware of the difference and for them, a compact document which could be approved as a Government Resolution was the priority. They knew how obligatory a Government Resolution is, being accepted by the Government, not just one Ministry. The others in ABPH, however, were in my understanding participating in a programme process which would produce a document containing main policy guidelines and also an action plan. This kind of comprehensive document, or series of documents, which I would call a health policy programme, should have however been approved only by the MSAH; it would have been too extensive to be approved by the Government.

Also, in the beginning of the 2000s, Government’s Resolutions were much more selective and weighty than at present. Therefore, it was very important for the MSAH to have a whole Government’s approval, and in this format Health 2015 was seen to be much more significant in terms of committing other Ministries than if it had been “a programme”. It is apparent that this division was very clear to

some respondents, while some others still do not understand why Health 2015 was called “a programme which is in fact a Government’s resolution”. One person said that in his opinion, the name implicit referred to some other document; “this is the resolution but there is also a programme”. I believe that this difference was not necessarily recognised during the process; it was so obvious to some key participants that they probably did not think that it is not as apparent to everyone, or that other participants would have some other kind of document in mind.

Due to lack of action plan in Health 2015, some respondents felt that it should have been produced immediately after launching the Government Resolution; in their opinion this kind of document did not engage anyone and no one knew what they should do. Also the lack of indicators was criticised and that goals are disconnected.

In recent years, however, the MSAH have worked on the shortcomings of Health 2015 and together with sector research institutes, it has developed e.g. indicators, and tools for monitoring and evaluation. Immediately in 2001 and 2002, the MSAH civil servants and Stakes officials toured around Finland and executed field trips to present Health 2015, and these tours have continued since then, involving also Ministers and other high-level decision makers. There have also been several seminars after 2001, some of them regularly every year nationwide. Besides Health 2015, these seminars and tours have addressed e.g. health promotion, social disparities in health, monitoring and indicators.

The fresh mid-term evaluation (Sosiaali- ja terveystieteiden ministeriön ja Terveystieteiden ja hyvinvoinnin laitoksen asiantuntijatyöryhmä & Kansanterveyden neuvottelukunta 2012) will discuss in detail all actions, programmes and projects which are linked to Health 2015 and how and if the objectives have been achieved.

9. RESULTS

In this chapter, I will present answers to the research questions which were presented in Chapter 2. These results will be discussed further in the final chapter.

(1) What is Finnish health policy?

Based on my study, I will divide this answer in two.

- I. National health policy defined by governmental institutions, mainly the MSAH and THL

This is the official and explicitly defined health policy which was presented in Chapter 6.1. It has historical roots, and it represents the health policy which is quoted in Ministerial speeches and official documents, and which is the basis for national and regional health-related programmes, projects and funding. I classify municipal health policy in this category as well, although, as a matter of fact, there may be several municipal health policies. However, the basis for operations lays in the official national health policy.

- II. Health policy generated by industry, media, trade unions, and partly also NGOs

This “unofficial” health policy may be generated through political parties and influence legislation, governmental agenda and administrative operations. It is not an explicit, comprehensive or coherent set of policy choices and objectives and varies depending on the issue. Health policy II may be evidence-based, but not necessarily.

These two policies may be in unison in certain questions, and especially the policies advanced by many NGOs belong often to group I. However, especially in questions regarding business, competition, various rights and professional position, the objectives of health policy II are not necessary equal to health policy I.

(2) Does someone actually coordinate Finnish health policy, and if so, who or which institution(s)?

The definition for coordination was presented in Chapter 2.1. My answer for this question is also two-fold: yes and no. Compared with the time when the National Board of Health still existed, there is no such coordinating body anymore. However, those tasks belong mainly to the MSAH and THL nowadays. Regarding legislation, programmes, projects, and funding, the MSAH and THL can be seen as coordinators and also initiators.

However, one problem in answering to this question is related to the institutional organisation of the MSAH and THL: from administrative viewpoint, the authority and power of THL stem in many ways from the MSAH, due to the performance agreement. Nevertheless, THL seems to be a quite independent actor as well, and some statements can be interpreted as disagreeing with the Minister or the MSAH (cf. e.g. Raeste & Ahokas 2012; THL 2012b).

Another problem is related to municipalities. After the state subsidy reform in 1993, the municipalities have become very independent. They still receive funding from the state, but in terms of authority and power, the position of state has significantly weakened. Therefore, in many cases it seems that the MSAH is *trying* to coordinate national health policy, but in reality it does not necessarily have a say in municipal operations and the current 336 municipals are executing each their own health policies. However, regarding power, the MSAH was reported for some reason not to execute all those sanctions which would be permitted by law, either.

Nevertheless, there have been some legislative changes recently. For instance, in Act on Health Care (1326/2010) there is a requirement for municipalities to produce a Welfare Review once in every term of the municipal council, and the Review has to be revised annually (THL 2012c).

This question and answer are clearly subordinate to the first one and reflect the current incoherency in health policy field. I was not able to find a single source for ideas or initiatives, but it seems that the MSAH and THL are at the moment the most probable sources (see also Kingdon 2011, p. 72).

I was not able to determine or confirm any leading individuals by names, either, but in terms of institutions, I would say that especially the senior management at the MSAH and THL are important from national health policy viewpoint. There are also some influential individuals in hospital districts, Duodecim, certain municipalities and NGOs, which were sporadically mentioned, but I could not conclusively confirm their real influence or importance.

(3) Is Health 2015 a public health programme; does it fulfil the criteria for a policy according to indicators drawn from policy analysis?

Referring to Chapter 8.4, my answer is no. Health 2015 is a Government Resolution and as such a general document defining national health policy objectives. Several central features associated with (good) policy programmes are missing in this document. As I have reported in Chapter 8.4, many shortcomings have however been supplemented afterwards. Nevertheless, my task was to evaluate the document that was published in 2001, so I have excluded the recent additions from my analysis. The current development is reported in the mid-term evaluation of Health 2015 (Sosiaali- ja terveystieteiden ministeriön ja Terveystieteiden ja hyvinvoinnin laitoksen asiantuntijatyöryhmä & Kansanterveyden neuvottelukunta 2012).

(4) Do the Health 2015 preparation process, content and actors reflect the implementation of New Public management (NPM) in Finnish public administration?

New Public Management has been discussed in detail in Chapter 4. Although some respondents mentioned to have explicitly noticed NPM-related influences in Health 2015 process, one person even named Chief of Staff and the Chairman of ABPH Markku Lehto to have been a strong advocate for NPM and administrative

reforms, it seems that regarding Health 2015, NPM was not advanced intentionally. However, there are many features that are characteristics to NPM, but it is probable that many of them are related to the period of time, and not necessarily especially to Health 2015.

1. The process and actors were affected by the 1990s recession, the state subsidy reform in 1993 and both Finnish EU membership (1995) and EU Presidency (1999). These events were significant in terms of lack of financial and human resources, which affected the schedule and the content of final document, but these events also affected administrative reform in public sector, including in the MSAH. It may be that even without the recession, these administrative changes would have taken place, especially regarding reorganisation of central government and decline in the number of public sector employees.
2. The abolition of the National Board of Health can be also seen in NPM context. This organisational reform removed a coordinating body from the health field and the Health 2015 process may have been different, if the National Board still had existed.
3. The programme itself, the concept of making policy through programmes, can be seen belonging to New Public Management. However, as I reported in 8.1, programmes in health sector have existed prior to Health 2015.
4. Horizontal preparation process, an extensive number of actors, and a bottom-up approach, instead of the more traditional top-down viewpoint, originated partly from WHO criticism but can also be seen in NPM framework. The possibilities of

citizens and “the field” to participate were emphasised, although the process was led by the MSAH – a governmental institution.

5. Advisory Board for Public Health was able to commission products and services from private actors, at least from Kuntakoulutus Oy and Juhani Lehto. There were also expressed demands for marketing and promoting Health 2015 for various stakeholders, which is not the traditional governmental approach.
6. The absence of “political” in the Health 2015 process and the resulting documents. Political parties or the Parliament were not formally included at any point during the process, also ministerial involvement seemed to be almost non-existent. The Government Resolution was planned and processed mainly by civil servants, experts and professionals, and in the final document, there is no reference to political parties, either.

However, of those NPM features that were discussed in Chapter 4, I could not recognise signs of change in leadership or attempts for more organised management if compared with traditional governmental bureaucracy.

10. DISCUSSION

Due to the extensive scope of my thesis, I will discuss the results and my observations in thematic entities. I will combine theoretical background, presented in chapters 2, 3, 4, and 5 with my research data reported in chapters 6, 7, and 9. In the end, I will present some recommendations which stem from my study.

Overture

As I showed in Chapter 5, health is political in many ways. The challenge of health policy is in its diversity: various policy domains affect health and there are all kinds of interests built in. In international context, Finland has been the pilot country for WHO during many decades, and WHO has influenced Finnish health policy more than any other actor. The role of EU in health policy seems to have increased surreptitiously. However, having a complete understanding of all effects may be difficult because there seems to be lack of EU related health policy research. Therefore, the MSAH may not have as much information as would be needed for policy making.

The reputation of Finland seems to be still good, although the role and position of Finland has slightly changed during the last ten years. In many fields of epidemiology and clinical research, Finnish researchers are highly successful and internationally acclaimed. However, health policy research has not such a strong position. In fact, the amount of health policy research can be said to be insufficient, and health policy research specifically from a political science point of view is practically nonexistent. In my opinion, Finland would still have a chance to regain its position as one of the leading countries in innovative health policy, and e.g. THL functions as an excellent resource for this work. Referring to Marmot Review (see Chapter 5.5): from economic perspective, investing in health is investing in the future prosperity of a country.

In Chapter 1, Introduction, I referred to Annukka Berg's doctoral dissertation which addresses environmental and consumer policy. I see that health and envi-

ronment are similar policy areas in many ways. For instance, changes are slow and already destroyed elements may be hard, even impossible, to repair. Also regarding consumption and consumer choices, environmental and health issues have similar challenges. Very easily the discussion is turned over to individual rights, accusation of restricting personal freedom, and instead of having regulations and standard solutions, it is argued that there should be actually more choices available for a customer or a consumer (including patients in healthcare).

I see that one solution to this dissonance would be applying the idea of so called "libertarian paternalism" (see e.g. Thaler & Sunstein 2009); not necessarily restricting choices, but making the good ones easier to access and more attractive than the bad ones. The Director General of THL, Pekka Puska, has also written about this approach, referring to the WHO Ottawa Declaration: "Make the healthy choice the easy choice, for policy makers as well" (Puska 2010, p. 62).

The friction between the state and municipalities dominates Finnish health policy. In theory, all 336 municipalities may run their health and social sectors as they wish, in legal framework of course. While many municipalities try to follow the general national guidelines, there are great differences in knowledge, capacity and resources between municipalities. These differences affect the quality and availability of health care, and the citizens do not have equal access to health services at the moment.

In my research, the role of industry, media, NGOs, and other interest organisations seemed to be very significant in current Finnish health policy. Especially women's magazines were considered important in health promotion, and it might be useful for the MSAH and THL to evaluate their media relations and strategies from this viewpoint as well, if they have not done it already.

Olavi Borg has pointed out (see Chapter 3.3) that one typical feature in corporatist development has been that it has been considered, or at least feared, to weaken the role of parliaments and bypass the traditional political-parliamentary machin-

ery. My results support this view. It seems that if political parties do not have a evidence-based societal health policy vision and they are not committed to health policy I, the sporadic policy decisions may be motivated by health policy II instead (see Chapter 9), perhaps unconsciously and results may contradict with objectives of health policy I.

I also find it quite peculiar that although health and social policy domain uses a lot of resources and is one of those fields which influence people's lives the most, it has not been appreciated in a male dominant political culture. The leading ministerial posts with the MSAH have not been considered important but rather very unpopular (c.f. Nousiainen 1992; Chapter 7.1).

Act 1: Institutions, decision making and policy changes

Despite recent administrative changes, the role of state is still important. Regarding institutional operations, there are many things that affect decision making. It seems that at least health policy making is still quite path dependent, but on the other hand, it is not path dependent necessarily on purpose, just because "we want to do things the way they are always done". Especially regarding Health 2015, the civil servants seemed to react to changing situations and make certain choices because they felt that those were the only ones available or the best ones in that political and bureaucratic atmosphere.

I did not investigate the content of Health 2015 so I am not able to review possible changes in policy content. However, governmental decision-making processes seemed to resemble Lindblom's concept of "muddling through" (see Chapter 3.1). In terms of content, I do not see what kind of major policy changes would have been necessary or what they could have even been. The only policy changes that I was able to detect, were the category of targets, the role of WHO in Finnish health policy and the role of health among other policy domains.

Finland has traditionally supported so called process targets, but in Health 2015 some quantitative targets were included, as well.

The role of WHO has changed for many reasons, one major one being the organisational change and financial problems of WHO. The EU affairs have also taken most of the resources of the MSAH civil servants. At the same time, the global health network has grown and become more complex, so there is less time for WHO. However, I noticed that already in 2000, the new ABPH had discussed the importance of WHO objectives in Health 2015 and someone had suggested emphasising the Finnish Constitution, instead.

For some decades ago, health and health policy were considered important in many political parties. It seems that recently, some other political ethos have been more appreciated, such as trade, industry, and economy. The connection between healthy population and economic success is not necessarily recognised, either. The current Finnish discussion around healthcare systems and health care is compatible with the two health policies of Busse and Wismar (see Chapter 5.5): the one which derives from the WHO and supports Health in All Policies, and the one which is merely concerned about managing the costs.

In the 1970s, 1980s and in the 1990s, WHO has been the most important source for Finnish health policy from policy transfer perspective (see Chapter 3.2). However, as the role of WHO has diminished and there have been new operators affecting global health (care) policy, such as the OECD and World Bank, it has also meant increase in NPM related content, partly influenced by the US. Therefore, at the moment it is not totally clear where ideas and influences come from. The Finnish healthcare system is also very complex and it has been built in several stages, always adding new blocks on the old ones, so there is practically no other system that Finland could learn from or transfer per se

In my research, the role of the MSAH was central (c.f. Mattila 2000), but THL was in many ways equally important. One thing being apparent in the recent public discussion on Act on Care Services for the Elderly (see e.g. Chapter 1) is the complex relationship between the MSAH and THL. In terms of authority and “marching order”, I found the relationship a little bit unclear. In theory, the structure and order is clear, but in practice there seemed to be some tension. I could not be sure if tension exists because of the institutional structure and history, or is it partly due

to persons. I find it interesting that although the MSAH is financing THL, some respondents said that THL does not necessarily produce that kind of information that the MSAH needs or has asked for. It was also challenging to comprehend the independent role in the context of institutionalism. However, I am not saying by any means that the independence would be wrong or undesirable but rather that I found it a bit confusing; on the other hand THL is subordinate to the MSAH, but it has an own strategy and it may express its own statements, if necessary.

Concerning THL, one problem may arise from the origin. The merger of KTL and Stakes was seen partly political and not necessarily being purely based on a need to combine these institutes. THL is also quite new and it is still developing, so it may be that we have not seen the final THL yet. One piece in this puzzle is the forthcoming nomination of the new Director General after Pekka Puska will retire in a few years. In my understanding, THL is one of those institutions which is allocated by political parties, and one respondent said that the new director will probably come from the SDP. Anyway, for the sake of Finnish health policy, health policy research and Finnish public health in general, I truly hope that despite possible political strings, the nomination will be based on expertise, vision, and leadership skills, and that this position will not become just another piece in political chess. THL with its excellent staff is also globally a so significant and unique institution that it should be treated accordingly.

As I have mentioned in several contexts, the state subsidy reform in 1993 was seen the most important factor for the current the tense situation between state and municipalities in terms of health care and in general. It seems to remain complex and problematic in the future as well, until some kind of municipal reform. The current number of municipalities, 336, is too high and small municipalities will not be able to secure equal and sufficient health care and preventive services in the future, due to aging population. However, the size of a municipality is not the only factor needed for securing good primary care, but also some structural changes must be done.

Due to the content of health policy and the fact that the medical profession has been in a central role, the demand for rational evidence-based decision making is

perhaps more apparent in health policy than in some other policy fields. However, as Kimmo Leppo has pointed out (see Chapter 5.4), health policy does not differ from other policy domains; there are always knowledge and values, also when health policy choices are presented neutral or value-free. However, referring to the reported lack of Finnish health policy research, I see that there is a difference between making political decisions based on scientific evidence (or despite known scientific evidence) and on the other hand, making political decisions which are based on various interests and perhaps incorrect impressions, but which are not necessarily associated with facts. I agree with Leppo and see that health policy making does not differ from other policies in essence. Nevertheless, as a voter and a citizen, I see that the “political” is more visible if I see what the alternatives have been and how my political decision makers have prioritised them. One example given in my interviews was the lowering of alcohol tax in 2004 (see Chapters 6.2 and 7.8) against the unanimous warning from health experts.

The same applies for transparency in decision making. In my interviews, it was stated that some NGOs have close connections with industry and these connections may affect their agenda. However, when the NGOs or individuals are called to the parliamentary hearings or when they are consulting the Government, their connections or possible competing interests are not visible, or in my information, even necessarily available. Therefore, the MPs do not have all the information which may affect the statement of the said experts. Also, I was not able to find explicit grounds for most of the experts and other participants who had been involved in drafting various versions of Health 2015 and influencing the content and priorities e.g. by giving a written statement. In my understanding, it is still the case that in many ministerial working groups and committees the members have “always” been certain persons and organisations, and changing them or questioning their legitimacy would be more notable than continuing with the old gang. In many cases, and if there were transparent principles, the same persons and organisations would probably be invited anyway because Finland is very small and the number of experts is limited. However, from institutional and partly also

democratic viewpoint, it is not the same to have or to not to have explicit and transparent arguments for including or excluding some party.

One institutional idea, which recurred often, was Ostrom's notion of various ways of understanding "an institution" (see Chapter 3.1). Especially during the interviews, but also related to some literature as well, I tried to stay alert to discover the underlying individual actors. Very often actors were referred to as institutions, as in "the MSAH thought", "the Government did" or "THL thinks", and I always tried to ask about the "who". In some cases the respondents were able to specify names, but in many cases it was not possible or they were not sure. However, as an institution, the walls, cannot make decisions without people, in my opinion there must always be someone or several individuals who are "the institution". It may be someone or several people currently working in the institution, but it may also be someone or some people who used to work in the institution, and through path dependency, the decision or policy has been transferred further.

People are important from behavioural viewpoint and in the framework of organisational learning. First of all, it seems that many political decisions are influenced by facts, values, and circumstances, but also personal relations and disagreements. Lack of communication or misunderstandings affect results and processes. Second, the working life has changed, and instead of permanent, long-term contracts, many people work part-time, in short projects, or staff changes are otherwise unavoidable. There are lot of public sector civil servants retiring soon and many of them have functioned as an organisational memory. Therefore, a lot of information will disappear, if it is not documented somehow. IT technology enables various technical solutions, but there are still varying systems for saving and documenting information e.g. in governmental institutions. For instance, the Finnish Ministry for Foreign Affairs is quite famous for its pedantry, while some other organisations not so much. The municipalities are facing the same situation, and especially when long-term employees are replaced by short-term substitutes and project workers, it is highly important to pay attention to institutional processes and policies to make sure that no information will be lost and newcomers may

have a smooth start. Operationalisation usually increases efficiency, and when dealing with delicate affairs, such as social security or patient information, this kind of “productisation” of certain processes and procedures will also secure equal treatment and minimise errors.

Act 2: Absence of party political

The absence of political parties and the Parliament was very visible in Health 2015. My informants confirmed that it seems that the official Finnish health policy, which is defined and repeated in governmental documents and ministerial speeches, and on the other hand, those health political decisions which are made in real life, do not necessary meet. The political parties also seem to be less interested in health and health policy than they were for some decades ago. Without political involvement, there is not political commitment either.

As I mentioned in Overture, health changes take time and the effects of today’s decisions may appear only after 10, 20 or even 30 years. Therefore, the results from health policy programmes and projects, such as those linked with Health 2015, may be evaluated only in the future and the current state of population health does not give the full picture of what has been done lately. Having said that, I must say that I found it quite alarming that my respondents agreed so strongly on the lack of political interest but at the same time saw that media, industry and various interest organisations rule the health policy game. To avoid misinterpretation, I emphasise that my stance is not to be read as blaming those who take the power if it is available, but merely as astonishment for party political blindness. I also understand why professions and other experts may feel that they do better if the political decision makers are not “interfering” with health policy issues but they should be left to professionals, instead. It also seems that in terms of health policy, the group of professionals has been expanded to industry and business as well. However, from the viewpoint of legitimacy of political decision making, I see it problematic if the priorities and contents are defined by people who are not elected or even vicariously liable for their actions, even if the decisions are formally made through political machinery.

In this context, however, two things must be mentioned. First, professor Markku Temmes has noted the recent increase in politically appointed staff in Finnish Ministries. Second, public choice theorists have also questioned the state's position as a neutral actor (see Chapters 3.3 and 4.4). I started to wonder, in fact, if there could be found "state political" ideas in comparison with party political or private interests. Currently it seems that at least municipals and state are in many questions on opposing sides, although they are in principle both considered to represent one actor: the public sector.

In a way, the lack of political and politics may be understood as non-policy making. Without a comprehensive schema and defined policy objectives, decisions are made separately and depending only on the situation. In health policy it may mean that decisions and results are contradictory and they do not support the objectives of the official national health policy; causalities are sometimes very complex. The situation gets even more challenging if there is no research information available on the matter or if its neglected. Not having a policy may be a policy, and removing party politics from processes is also a political act, although it would not be in any way intentional.

Regarding the absence of Parliament, few things came to my mind. First, Wismar and Busse (see Chapter 5.5) have noticed the absence of national and regional parliaments in health target programmes, so Finnish situation is nothing new. However, after Health 2015, the role of Parliament seems to have even diminished in general policy making. Several respondents commented that the significance of Government Programme has increased and in principle, the hands of an MP or an individual Minister are tied for the four-year term. From the viewpoints of democracy and parliamentarism, I find it problematic although I understand why these coalition Governments or political parties have seen the need to draft a very detailed programme to avoid problems and to keep the Government together. Nevertheless, if the role of the Parliament is indeed just ceremonial, or at least not very powerful, the shift in power is again transferred towards nonelected actors. The significance of negotiations on the new Government and the content of the Government Programme has grown, and while the current Programme is

actually fairly good in terms of public health, the basic problem is that those issues and policy choices which have an advocate, perhaps an interest organisation, in the negotiations will have better chances to end up in the Programme. On the other hand, those issues which are not represented in the negotiations and will be left out, will be postponed for the whole four years. In addition, in the era of constant global changes and surprises, there are matters that cannot be planned ahead or postponed for many years. From the viewpoint of Kingdon's stream model (see Section 2.2.2), in current practice the window of opportunity may therefore be closed for four years. Regarding consistency of politics and policies, "calming down" the working environment and concentrating only on certain issues may be welcomed, especially among civil servants. However, having cast-iron Government Programmes may not always serve the public good.

As I am writing this, there is one interesting legislative proposal (LA 2/2012 vp) waiting for Legal Affairs Committee discussion in the Parliament. The proposal for same-sex marriage was initiated by MPs, although it was excluded from the Government Programme. What makes this proposal even more interesting is the first signatory to the proposal: the current Minister for European Affairs and Foreign Trade Alexander Stubb. It will be interesting to see how this issue proceeds; if the proposal will ever be sent to the Plenary Session and what will happen in voting.

Act 3: Health care and professions

I have not investigated healthcare systems, but regarding professions and their interaction, I made two observations. First, it is no news that health professions are highly hierarchical. However, if the history is disregarded, one reason for the still existing distance may be that it seems that the students of medicine, nursing and other healthcare professions do not have much interaction even during their studies. Therefore, when graduating, the new health professionals have mainly spent time among their peers and future colleagues, and their perception of "the others", their skills, roles, and tasks e.g. in various working environments may be almost nonexistent or incomplete. This is apt to maintain prejudices and it can also affect patient care and safety, if the professionals do not genuinely work in teams or even know how their colleagues could help them.

My understanding is that the trade unions do not have much interaction either, if some yearly meetings and seminars are not taken into consideration. I am well aware that the curriculums are very full already, especially in the Faculties of Medicine, but I still argue that having interaction already during the studies could affect the quality of professional teamwork after graduation, as well. Better working environment means happier employees, and ultimately it would be good for everyone, also patients. Some universities and polytechnics may have already made an effort into this direction, but not all of them. In my opinion, trade unions could be natural initiators and good mediators in interprofessional cooperation, and the new strategy of the FMA, in emphasising collaboration and partnership, could be an excellent starting point.

Second, when talking about health promotion or primary prevention, it seems that medical and nursing professionals may understand the concept in a slightly different way (cf e.g. Rose 2008). This difference in perception may cause friction when discussing the content of duties of various health professions.

In general, the views on influence of trade unions varied, and the FMA was seen to be the most influential if any. However, I would like to distinguish the influence of professions and on the other hand, the influence of trade unions representing those professions. It seems that there are influential health professionals who are not member in any trade union, for various reasons. However, this topic would require further investigation.

The final remark regarding healthcare is not by any means the least important. Finland, the land of technology, has not been very successful in implementing various healthcare IT structures and systems. They are highly expensive, there are massive problems, some of them even life-threatening, resources are wasted, and all the “extra” money and time could be used for taking care of patients. In 2009, the share of healthcare sector was 13% of all public sector IT management expenses, and for instance the National Audit Office of Finland has strongly criticised poor management of these projects and pointed out that the results have been quite modest compared with need and objectives (Valtiontalouden tarkastusvirasto 2011). The appointment time per patient has not increased com-

pared with the “old times”, but IT systems are so complicated and unreliable that in practice, they use much more human resources, than the old fashioned paper file system, due to technical problems. As a result the amount of time per patient, and the amount of patients per day per physician are diminished, which is detrimental to the whole public healthcare system. When the absence or reduction of clerical personnel is added to this equation, meaning that quite well paid physicians are also taking care of many so called running errands, the system does not sound very smart. In terms of patient safety, the situation is also alarming: IT systems do not necessarily record changes regarding e.g. medication, various systems are not compatible even in the same institution, appointments disappear, or in the worst case a physician cannot access the patient’s files at all.

One innovative example of trying to find a solution to this disastrous situation was born in social media for some time ago. There is an open Facebook group called “Terveystietojärjestelmät korjattava”³⁰ [The healthcare IT systems must be fixed] and there are already almost 240 IT specialists, physicians, administrators, consultants, researchers, and other kinds of interested people participating in the discussion. This kind of modern social media interaction is an extremely good way to collect information.

Final act: Health 2015

Finally, I will present a short analysis on Health 2015 and some answers to “why?”. As I have reported in Chapter 8, the final document and therefore the result of the Health 2015 process was very different from what many participants expected. The objective was to produce three separate policy documents and several handbooks, perhaps some other material as well, but Health 2015 is a combination of those three, lacking many health policy specific features, and the only handbook which was prepared was never finished. The Parliament was not involved in the process, although plenary discussion was originally planned. Political parties were not met or informed either, and I learned that it is not custom-

³⁰ <https://www.facebook.com/groups/407836109267293/>

ary for a Ministry to ask political parties for a statement, it has been considered to be too “binding”. The preparation schedule, programme structure and content priorities were revised several times, and eventually Health 2015 was published over a year later than what ABPH had planned in the beginning. Besides the editing work done by Juhani Lehto in the end of the process, ABPH could not have any professional help for editing the background document or communicating with media.

During the interviews, some respondents described their feelings by saying “then something happened”, and that was one of my motivations for investigating this case. In Section 2.2.2, I referred to Merelman who has compared policy analysis with psychotherapy. I have always been interested in psychiatry and psychology, and while I totally agree with the similarities, I also realised that my research process may have been indeed therapeutic for many people, and I have functioned as a kind of therapist. Everyone that I interviewed felt that they had done their best and worked very hard, and I hope to be able to answer some of those questions that the respondents may have had during these years.

The process was described as being fun and very rewarding but also very hard. Some people even mentioned that they seem to have forgotten some years because they were so tired and exhausted all the time. At the same time, many people who were involved in the process, encountered criticism from the field, and although they felt that they had given everything and more, they still did not know why the document eventually became that kind of a compromise and what exactly had happened. Some people, on the other hand, were satisfied with the document and in their opinion it was exactly the way it was supposed to be. There were probably over a thousand individuals involved in Health 2015 process altogether, and many respondents felt that four years and extremely many working hours of many people were lost.

Why, then, the process and the result were like that?

My analysis is in short: too many things happening at the same time. To be more specific: lack of resources, and leadership and organisation, but also absence of

political involvement and commitment. Many organisational changes, both structural and personnel-related, happened in a very short time. The EU Presidency was very laborious for the MSAH; the same civil servants preparing and running the term were also responsible for Health 2015. Also Kimmo Leppo's absence both from the MSAH and from the process was a major factor in my opinion.

In addition, from an institutional viewpoint, having three ministers in a short time, all representing small parties, has been an extremely challenging situation for the whole MSAH, especially for civil servants. In terms of coherent administration and policy making, these four years were experienced as "wasted" because there were changes all the time.

During the Health 2015 process, there were also structural changes in the MSAH. The departments were re-organised, which caused a great tension between several actors and one respondent described the situation by saying "we spent the whole year fighting with each other".

Because of all this, the documentation and archiving suffered, and after changes in personnel, there was a gap for several months, even five or six, before Taru Mikkola came to replace Merja Saarinen in ABPH. Due to unfortunate timing, there was not a natural transfer of information and knowledge, which would have been absolutely necessary, as Saarinen was at that time the key person in the MSAH in terms of Health 2015.

As a cherry on a cake, there were reported to be also some personal differences, which may have influenced the process in a negative way.

All in all, it seems that because of the 1990s recession and the EU activities, the MSAH did not have resources to hire or appoint anyone to lead and coordinate the process full-time. Therefore, it did not always have a straight course. On a positive note, the people involved were extremely enthusiastic, professional and active, and this kind of horizontal and comprehensive preparation process was considered to be very good. The downside is that the people involved were extremely enthusiastic and active. One respondent mentioned that although the open discussions and participation in seminars were welcome, he did not see the

point in everyone sharing their random thoughts, priorities and ideas, but it was not very clear if they have any effect on anything or how they are related to anything.

Due to the enthusiasm, there was an avalanche of raw material, which could not be processed. One of the biggest losses was the lost enthusiasm and active professionals, as they could not be engaged in the Health 2015 process afterwards. There were no database, email contact list, coherent information on the seminar participants or other involved parties at the MSAH, Stakes or KTL. Due to changes in personnel and the abundance of other duties of the responsible civil servants, the archiving seems to have been simply forgotten.

As I wrote in the beginning of this chapter, with respect to absence of “political”: without political involvement, there is not political commitment either. Even if the process would have been more successful, and instead of one, three documents would have been produced, it may be that the priorities and goals would not be more visible in the daily political decision making than what they have been now.

I was told that the parliamentary discussion was opted out for two reasons. First, it would have taken a long time due to bureaucracy and the process was delayed already. Second, the policy of the Government was reported to have changed and there was not any political will to take this kind of document to the Parliament. Apparently the Government, or/and some civil servants in the MSAH, were worried that the MSAH opens the Pandora's box if Health 2015 will be sent to the Parliament. It was mentioned that there was a new preference for processing documents at a lower level, which meant Government approval instead of parliamentary discussion. Therefore, the document was accepted as Government Resolution, and as such, it was more obligatory than "just" a public health programme produced by the MSAH.

To end on a high note, what is positive over all is, getting back to the title of my thesis and at the same time closing the circle:

“The patient survived, despite the treatment”

By this statement I refer to the fresh evaluation of Health 2015 (Sosiaali- ja terveysministeriön ja Terveysten ja hyvinvoinnin laitoksen asiantuntijatyöryhmä & Kansanterveyden neuvottelukunta 2012) which shows that after all, and although the document per se is not very well known, it has still succeeded to improve population health in Finland. The goals have been advanced through many other programmes and projects, so even if municipal actors do not recognise Health 2015 by name, the goals and policies are usually found in the municipal strategy documents.

Coda

Suggestions for research topics:

- What kind of professional and educational background do the MSAH civil servants have? How about THL? Is the dominance of medical profession just a myth or reality?
- Is the influence of professions and trade unions considered to be one, or is there a need to distinguish these groups?
- Politics of health policy in Finland; have various governmental compositions affected Government Programmes in terms of health policy and if they have, how? Have various compositions affected the executed decisions and legislation in terms of health?
- Is the influence of those interest organisations and NGOs which have participated or being represented in Government negotiations, recognisable in Government Programmes?
- Where do the present influences come to Finnish health policy? Is there policy transfer? What is the current role of WHO as a source?
- Network analysis on core actors in Finnish health policy making.
- Cooperation between industry and NGOs, are there strings attached?

Recommendations for administration:

- Relocation of the Advisory Board for Public Health from the MSAH to the Prime Minister's Office and strengthening its resources. This would enable true health policy coordination and monitoring in the spirit of HiaP which Finland has been advancing also in the European Union.
- Making the possible competing interests of individuals and organisations, which have been invited to a parliamentary hearing, transparent. This would give MPs a better chance to evaluate the given information and possible background influences.
- Definition of transparent attributes for qualification for expert consultations, working groups, hearings, and written statements.
- Application of the British White Paper type of mechanism for discussing important societal matters and for collecting statements and feedback for (health) policy initiatives³¹. It would also enable participation of political parties, including opposition.
- Increasing the amount of health policy research in universities and THL
- Reactivating civil servant health policy exchange programmes with prestigious foreign institutions.
- Utilising NPM-motivated ideas of marketing, creative thinking, leadership and management also in public sector, when applicable. Cooperating with creative societal actors, such as think tank Demos.

³¹ <http://consultations.dh.gov.uk/healthy-people/healthy-people>

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FOOTNOTES

1. KvaliMOTV 6.2.4 / Edustavuus: http://www.fsd.uta.fi/menetelmaopetus/kvali/L6_2_4.html
2. National Archives Service of Finland: <http://kronos.narc.fi/menehtyneet/>
3. Heroes of Public Health - Leo Kaprio, MD, DrPH, MPH:
<http://commprojects.jhsph.edu/sphheros/default.cfm?detail=38>
4. Academy of Finland / Research programmes: <http://www.aka.fi/en-GB/A/Programmes-and-Cooperation/Research-programmes/>
5. The MSAH / Departments: <http://www.stm.fi/en/contact/departments>
6. The MSAH / Social and health services / Legislation:
http://www.stm.fi/en/social_and_health_services/legislation
7. THL / Ajankohtaista / Tiedotteet / Sosiaali- ja terveydenhuollon palvelurakenne-esitys antaa hyvän pohjan jatkovalmistelulle: http://www.thl.fi/fi_FI/web/fi/tiedote?id=30059
8. Healthier Northern Finland: <http://sp.terps.foral.fi/default.aspx>
9. Finnish environmental administration:
<http://www.ymparisto.fi/default.asp?node=8103&lan=fi>
10. Marttaperinne / Terveys ennen kaikkea!: <http://www.marttaperinne.fi/aikajana/1970/terveys-ennen-kaikeaa/>
11. Heart Symbol - a better choice:
http://www.sydanmerkki.fi/sydanmerkki_tuotteet/etusivu/fi_FI/englanniksi/
12. Terveystieteiden akateemiset johtajat ja asiantuntijat ry: <http://www.taja.fi>
13. Suomen Bioanalyttikoliitto ry: http://www.bioanalyttikoliitto.fi/en_english/
14. The Federation of Public and Private Sector Employees, Jyty: <http://www.jytyliitto.fi/Sivu/in-English>
15. Suomen Terveystieteiden ammattiliitto STHL ry: <http://www.terveydenhoitajaliitto.fi/>
16. Suomen Toimintaterapeuttiliitto ry: <http://www.toimintaterapeuttiliitto.fi/>
17. Suomen Työterveyshoitajaliitto ry: http://www.stthl.net/fin/in_english/
18. Finnish Dental Association: <http://www.hammaslaakariliitto.fi/index.php?id=6404>
19. The Finnish Nurses Association: http://www.nurses.fi/the_finnish_nurses_association/
20. Suomen lähi- ja perushoitajaliitto SuPer: <http://www.superliitto.fi/en/>
21. Talentia: <http://www.talentia.fi/en/>
22. About JHL: http://www.jhl.fi/portal/en/about_jhl/
23. Yksityisen Sosiaali- ja Terveysalan Ammattilaiset ry: <http://www.ystea.fi/ystea/mikonystea/>
24. [two literature references, see Bibliography]
25. Kill or cure? Help to make sense of the Daily Mail's ongoing effort to classify even inanimate object into those that cause cancer and those that prevent it: <http://kill-or-cure.herokuapp.com/>

26. Valtioneuvosto / Pääministeri Paavo Lipposen hallituksen ohjelma 13.4.1995:
http://valtioneuvosto.fi/tietoa-valtioneuvostosta/hallitukset/hallitusohjelmat/vanhat/lipponen/Hallitusohjelma_-_Lipponen112834.jsp
27. Valtioneuvosto / Pääministeri Paavo Lipposen II hallituksen ohjelma 15.4.1999:
<http://valtioneuvosto.fi/tietoa-valtioneuvostosta/hallitukset/hallitusohjelmat/vanhat/lipponenII/fi.jsp>
28. Asetus kansanterveyden neuvottelukunnasta 67/1997; HE 230/1996 vp; StVM 37/1996 vp
29. Think thank Demos Helsinki: <http://demos.fi/English>
30. Facebook / Terveystietojärjestelmät korjattava:
<https://www.facebook.com/groups/407836109267293/>
31. Department of Health / Healthy Lives, Healthy People Consultation
<http://consultations.dh.gov.uk/healthy-people/healthy-people>

APPENDIX 1. THE TEMPLATE FOR INTERVIEW QUESTIONS

These questions were presented in Finnish and the order varied slightly. For more detailed discussion, see Chapter 2.

Section A

1. In your opinion, who and/or which actor coordinates Finnish health policy? [The verb “coordinate” was explained to the interviewees, see section 2.1]
2. In your opinion and in the context of health policy, is the relationship and division of work between the MSAH and sector research institutes functional?
3. In your opinion and in the context of health policy, is the relationship and division of work between the MSAH and municipalities functional?
4. In your opinion, which countries and/or international organisations have influenced Finnish health policy the most? Can you give some examples of how this influence is visible? Has the situation changed e.g. in the last 20 years and if, why?
5. How do you see the role and influence of Finnish health sector trade unions (e.g. the FMA, They, SuPer and similar) in Finnish health policy, for instance regarding content or decision making? In your opinion, has their role changed e.g. in the last 20 years and if, why?
6. How do you see the role and influence of political parties in Finnish health policy? How do you see the role of the Parliament and/or Ministers, in other words: political actors?
7. How do you see the role and influence of patient organisations and other NGOs in Finnish health policy? Is there an organisation or several organisations which are more influential than some others?
8. How do you see the role and influence of the industry (e.g. pharmaceutical companies and food industry) in Finnish health policy? In your opinion, does industry lobbying influence health policy decision making and decisions in Finland?
9. How do you see the role and influence of media in Finnish health policy?

Section B

1. Who or which institution(s) has prepared health policy programmes before the Advisory Board for Public Health?
2. In your opinion, when has Finnish health policy become programme-led and why? How do you see programmes as tools in steering and implementing health policy?

3. In your opinion, why was Health 2015 made?
4. How would you describe Health 2015 preparation process? In your opinion, was the process successful or unsuccessful, and why?
5. In your opinion, how was Health 2015 and the process resourced?
6. In your opinion, when you think about the Health 2015 process and the final document, were there signs of implementation of NPM and/or the recent public administration reforms? If yes, would you give some examples? [Features of NPM were explained to the interviewees; see chapter 4]
7. When you think about the actors participating in the process of Health 2015, would you say that there were right individuals, organisations, and/or professions involved? If not, why? Do you feel that some group or groups were over- or underrepresented?
8. What is your opinion on the final document?
9. I noticed in the minutes that the ABPH was planning to create a more comprehensive programme which would include detailed objectives, actors, indicators etc. I also noticed plans for producing several handbooks for various stakeholders. However, the final document was slightly different from the plans. Do you know if the municipal or other handbooks were finished and if not, why? In your opinion, why was the more comprehensive programme document never published?
10. There are no indicators for evaluating the programme, why is that, in your opinion?
11. There are also not very clear definition of actors and/or who is responsible for doing what, but the participation sounds volunteer. Why is that, in your opinion?
12. I noticed in the minutes, that the ABPH would have wanted to give Health 2015 to the Parliament to be discussed in the plenary session, but if I understood correctly, it never happened? Why is that in your opinion? Would you consider it surprising or more conventional, considering your experience on similar policy processes?
13. I also noticed that you had discussed contacting political parties and discussing health policy and this programme process with them, regarding parliamentary election in 1999. Do you remember that someone or for instance the whole ABPH would have contacted political parties and/or have a meeting with them? If not, would you evaluate why?
14. On which grounds did the ABPH select and contact the experts and stakeholders who were asked to participate in early drafting of the chapters?
15. On which grounds did the ABPH select and contact the experts and stakeholders who were asked for a written statement in 1999?
16. Based on minutes, I noticed that ABPH would have wanted to have professional help with editing the document(s) and to communicate with media. Do you

remember if there was this kind of professional help and if, what kind? If not, why was that, in your opinion?

17. When you think about Health 2015 process, do you remember if there was any argument or disagreement between organisations or individuals, for instance regarding mandate, authority, priorities or some other matters? If yes, how did that show? Did it affect the result, in your opinion?

18. In your opinion, how were the members for ABPH chosen in 1997?

19. If you think about the implementation of Health 2015, what is your opinion? Why?

20. The programme period was 15 years. Do you remember how that was decided?

Section C

1. The objectives of Finnish health policy have been to secure the best possible health for the population and to minimise disparities in health between different population groups. In your opinion, how successful Finland has been in achieving these objectives? Why?

2. What do you think about this statement: “in Finnish health policy, the rhetorical objectives and will, and on the other hand, executed political actions do not meet”? Why?

3. In your opinion, is Finnish health policy usually understood as comprehensive societal policy or as healthcare policy? Why? Has the focus changed e.g. in the last 20 years?

4. What is your opinion on Finnish health policy education and knowledge? Do you think there is enough academic education, research, and health policy expertise? If there is, where would you say that exists (e.g. in an university, research institute, or some other organisation)? If there is not, what should be done, in your opinion?

5. How do you see the international public health and health policy reputation of Finland? If you think about the past 20 years, has the Finnish position or reputation changed? If it has, why?

6. I noticed that of other Nordic Countries, Sweden appears very often as an example, and Finland is very rarely mentioned in health policy articles and journals. Finland is strong in epidemiology, but Sweden is more visible in health policy. Why is that, in your opinion?

7. How do you see health policy and public health research funding in Finland? Is it possible to execute comprehensive health policy and/or public health research? Is there some or several subfields which would be emphasised? In your opinion, should research funding be developed or improved somehow and if, how?

APPENDIX 2. LIST OF INTERVIEWEES

The interviewees are listed in chronological order. The institutions or roles in this list refer to the position these persons were interviewed in, and it should not be interpreted as complete. Most informants have worked in several organisations and in several positions, and it was not possible to list all of them here. For further details, see Chapter 2.

Name	Institution or role	Time, place
Matti Rimpelä	Stakes, University of Tampere	16.4.2012, Café Ekberg
Seppo Koskinen	THL, Health 2015	17.4.2012, THL
Mikko Kautto	Stakes, Health 2015	18.4.2012, Finnish Centre for Pensions
Jussi Huttunen	KTL, Health 2015, Duodecim	20.4.2012, Café Aalto
Merja Saarinen	MSAH, Health 2015	20.4.2012, Bulevardin Kahvihuone
Juhani Lehto	University of Tampere, Health 2015	23.4.2012, Ravintola Loiste
Markku Lehto	MSAH, Health 2015, University of Turku	25.4.2012, Ravintola Loiste
Vappu Taipale	Stakes, Health 2015, MSAH	2.5.2012, Café Strindberg
Juha Teperi	Stakes, MSAH, WHO, EU	4.5.2012, Sokos Vaakuna
Kimmo Leppo	MSAH, WHO, EU, Health 2015	4.5.2012, Café Aalto
Osmo Soininvaara	MSAH, Health 2015, Parliament of Finland	7.5.2012, Parliament of Finland
Tapani Melkas and Jarkko Eskola	MSAH, National Board of Health, Health 2015	9.5.2012, Home of Tapani Melkas
Timo Ståhl	THL, WHO, EU	11.5.2012, phone interview
Pekka Puska	THL, KTL	14.5.2012, THL
Heikki Pärnänen	FMA	15.5.2012, The FMA
Taru Koivisto	MSAH, Health 2015	16.5.2012, The MSAH

APPENDIX 3. LIST OF UNPUBLISHED DOCUMENTS

Code	Minutes of the Advisory Board for Public Health
M1	Pöytäkirja 1/1997 19.5.1997
M2	Pöytäkirja 2/1997 18.8.1997
M3	Pöytäkirja 3/1997 21.10.1997
M4	Pöytäkirja 4/1997 5.12.1997
M5	Pöytäkirja 1/1998 27.2.1998
M6	Pöytäkirja 3.3.1998
M7	Pöytäkirja 2/1998 28.4.1998
M8	Pöytäkirja 3.9.1998
M9	Pöytäkirja 1/1999 25.1.1999
M10	Pöytäkirja 2/1999 29.3.1999
M11	Pöytäkirja 3/1999 2.6.1999
M12	Pöytäkirja 4/1999 15.10.1999
M13	Pöytäkirja 31.3.2000
M14	Pöytäkirja 1/2000 19.6.2000 [The first meeting of the new Advisory Board for Public Health]

Code	Minutes of the Programme Division
M15	Pöytäkirja 11.9.1997
M16	Pöytäkirja 2/1997 7.10.1997
M17	Pöytäkirja 6/1998 15.5.1998
M18	Pöytäkirja 1/1999 12.1.1999
M19	Pöytäkirja 3/1999 31.3.1999
M20	Pöytäkirja 4/1999 21.5.1999
M21	Pöytäkirja 5/1999 24.8.1999
M22	Pöytäkirja 6/1999 27.8.1999

Code	Minutes of the Working Division
M23	Pöytäkirja - väliaikainen työjaosto 10.6.1997
M24	Pöytäkirja 24.9.1997
M25	Pöytäkirja 6.10.1997
M26	Pöytäkirja 10.11.1997
M27	Pöytäkirja 8.12.1997
M28	Pöytäkirja 28.1.1998
M29	Pöytäkirja 6.3.1998
M30	Pöytäkirja 20.4.1998
M31	Pöytäkirja 24.8.1998
M32	Pöytäkirja 7/98 5.11.1998
M33	Pöytäkirja 1/1999 8.1.1999
M34	Pöytäkirja 10.11.1999

Code	Minutes for Implementation Division
M35	Pöytäkirja 19.9.1997
M36	Pöytäkirja 4.11.1997
M37	Pöytäkirja 26.11.1997
M38	Pöytäkirja 29.1. 1998
M39	Pöytäkirja 6.3.1998
M40	Pöytäkirja 22.4.1998
M41	Pöytäkirja 3.6.1998
M42	Pöytäkirja 19.8.1998
M43	Pöytäkirja 1.10.1998

Code	Other documents
D1	Kansanterveyden neuvottelukunnan asettaminen / STM, 13.3.1997; Dno 130/041/96

- D2** Muistio: Kansanterveyden neuvottelukunnan toimeksianto ja lähiajan tehtävät / Tapani Melkas 12.5.1997
- D3** Kokouskutsu: Väliaikainen kansanterveyden neuvottelukunnan työjaosto 30.5.1997
- D4** Kooste ohjelmajaoston näkökulmista ohjelmatyön käynnistämiseksi, luonnos 11.9.1997 keskustelujen perusteella
- D5** Näkökohtia dokumenttiin Health for All in the 21st Century, a draft policy for the European region (STM Kansainvälisten asioiden toimisto pyytänyt lausuntoa 20.10.97 mennessä, DrO 8/332/97), luonnos 22.9.1997
- D6** Toimeenpanojaosto: ehdotus Terveyttä Kaikille 21.vuosisadalla -ohjelman ja siihen liittyvien osaohjelmien toimeenpanon valmisteluprosessiksi 22.9.1997
- D7** Toimeenpanojaosto: ehdotus TK 21. vuosisadalla -ohjelman valmisteluprosessiksi, luonnos 6.10.1997
- D8** Työjaosto: Ehdotus Terveyttä Kaikille 21. vuosisadalla -ohjelman valmisteluprosessiksi, luonnos 6.10.1997
- D9** Toimeenpanojaosto: Ehdotus toimeenpanojaoston työsuunnitelmarungoksi, luonnos 3.11.97
- D10** Toimeenpanojaosto: jaoston tehtävien määrittely 3.11.1997
- D11** Toimeenpanojaoston työsuunnitelma 4.11.1997
- D12** Kansanterveyden neuvottelukunta/Mikko Kautto: Terveysohjelmaintentaario (alustava versio) 5.12.1997
- D13** Kutsulista: Kansanterveyden neuvottelukunta 1/98 seminaari, 18.12.1997
- D14** Jaostojen työsuunnitelma 1998
- D15** Kansanterveyden neuvottelukunnan ja sen jaostojen työsuunnitelma ja "pohjat" aikataulutukselle loppuvuodelle 1998 (taulukko)
- D16** Kansanterveyden neuvottelukunnan ja jaostojen työsuunnitelma vuodelle 1998 (taulukko)
- D17** Seminaari: TK 2000 Suomen kansallinen ohjelma - missä onnistuttu, mitä on opittu, miten eteenpäin? Paasitorni, 21.1.1998
- D18** Luonnos kansanterveysohjelmien analyysikehikoksi / Seppo Koskinen ja Mikko Kautto, 26.1.1998
- D19** TK-21-ohjelman toimeenpanon tukiprosessi - ehdotus päätuotejaosta (MPy 26.02), 1998
- D20** Kansanterveyden neuvottelukunta, Tulevaisuusseminaarin suunnitteluryhmä 27.2.1998
- D21** Kansanterveyden neuvottelukunta: neuvottelukunnan työn lopputuote, luonnos 3.3.1998
- D22** TK 21 -ohjelman toimeenpanon tukiprosessi 5.3.1998
- D23** Tarjous: TK 21 -ohjelman toimeenpanon tukiprosessi - strategiatyökirjan laadintaprosessi / Markky Pyykkölä, Kuntakoulutus Oy 6.4.1998
- D24** Terveyttä Kaikille 21 (TK 21) Luonnos ohjelmakirjan rungoksi 9.4.1998
- D25** Kansanterveyden neuvottelukunta: neuvottelukunnan työn lopputuote, luonnos 20.4.1998
- D26** Terveyttä Kaikille 21 (TK 21) Luonnos ohjelmakirjan rungoksi 22.4.1998
- D27** Liite 2 TK 21 -ohjelmakirja-valmistelu, toiminnan kentät 28.5.1998
- D28** Terveyttä Kaikille 21 (TK 21) Luonnos ohjelmakirjan rungoksi 20.8.1998
- D29** TK-21-luonnos 20.8.1998
- D30** Yhteenvetoraportti asiantuntijalausunnoista / Eija Ikonen 17.9.1998
- D31** Alustava seminaarisuunnitelma: Väestöryhmien välisten terveyserojen supistaminen (21.-22.9.1998)
- D32** Sähköposti: Seppo Koskinen ja Mikko Kautto, 12.10.1998 11:35:01
- D33** Suunnitelma toiminnan kenttien kenttävastuuhenkilöistä ja -vastaista 13.10.1998
- D34** Luonnos Terveyttä kaikille 21 (TK 21) -ohjelmakirjan rungoksi sekä valmistelun aikataulu ja vastuuhenkilöt 2.11.1998
- D35** Päivitetty ohjelma 5.11.1998

D36	TK 21-ohjelma-asiakirjan valmisteluprosessi, luonnos 5.11.1998
D37	Ohjelma-analyysien yhteenvetotaulukko / Mikko Kautto ja Seppo Koskinen, joulukuu 1998
D38	Ohjelmajaoston elämänkulkutyöryhmän loppuraportti / Elämänkulku ja terveys - yhteenvedo ja päätelmät 31.12.1998
D39	Muistio: Kansanterveyden neuvottelukunnan ohjelman arvolähtökohdista / Juhani Lehto 11.1.1999
D40	Kansanterveyden neuvottelukunnan esityslista 25.1.1999
D41	Muistio: Täydentäviä näkökohtia ohjelman arvolähtökohtiin / Hannu Uusitalo, Stakes 25.3.1999
D42	Terveyttä kaikille 21 miniseminaarit keväällä 1999, tilanne 26.3.1999
D43	Lausuntopyyntö: Ohjelmajaos pyytää asiantuntijoilta lausuntoa ja kommentteja Terveiden edistäminen ja tutkimus -luvusta 1.5.1999
D44	Ohjelma: "Terveyttä yhdessä"-Terveyttä kaikille 21-ohjelman avoin valmisteluseminaari, Paasitorni 4.5.1999 / STM ja kansanterveyden neuvottelukunta
D45	Seminaarimuistio: "Terveyttä yhdessä" - Terveyttä kaikille 21 -ohjelman avoin valmisteluseminaari / Terhi Hermanson, STM 4.5.1999
D46	TK 21 -tavoiterihti, tavoitteiden muotoilu / kansanterveyden neuvottelukunnan asiantuntijat, sihteerit, STM:n osastopäälliköt Kimmo Leppo ja Jarkko Eskola, 27.8.1999
D47	Kuntatyökirjan viimeinen versio / Kuntakoulutus Oy 17.12.1999
D48	Terveyttä kaikille 21 -taustamateriaali 21.12.1999
D49	Muistio: TK21 - Mitä voitaisiin sanoa ohjelman arvolähtökohdista arvolähtökohdista / Juhani Lehto 11.1.1999
D50	Tilaus: työtilaus Juhani Lehdolta / STM 18.2.2000
D51	TK 21 "Lyhyt ohjelmallinen asiakirja / Valtioneuvoston päätös" / Juhani Lehto 10.3.2000
D52	Yhteenvedo Terveyttä kaikille 21 -taustamateriaaliin saaduista kommentteista / Merja Saarinen, 31.3.2000
D53	Ehdotus: TK 21 Rakenne / Juhani Lehto 9.5.2000
D54	Liite 3 Terveyttä kaikille kansalaisten arkielämän areenoilla terveyspolitiikan tuella 12.6.2000
D55	Luonnos: "Valtioneuvoston päätös", muokattu Juhani Lehdon 30.5.2000 tekstistä 12.6.2000
D56	Pressmeddelande: Nationella mål för folkhälsan / Regeringskansliet, Socialdepartementet 23.10.2000
D57	Health for All Policy in a Pilot Country: The Case of Finland / Kimmo Leppo
D58	Terveystiedon edistämisen strategiatyökirjan suunnitteluprojekti - alustava projektisuunnitelma
D59	Terveystietoon suunnattuja ohjelmia (taulukko)
D60	TK 2000 -arviointiseminaarin palaute / Meri Koivusalo ja Päivi Santalahti: Terveyttä kaikille kohti 2000-lukua ja sektorien välinen yhteistyö
D61	TK 21 -ohjelmaluonnos, 8. Muuttuva hallintojärjestelmä ja terveyden edistämisen mekanismit / Kerttu Perttilä
D62	Vaaratekijöihin suunnattuja ohjelmia (taulukko)
D63	Kansanterveyden neuvottelukunnan asettaminen, STM784:00/15/07/1999

APPENDIX 4.

THE MEMBERS AND DEPUTY MEMBERS OF THE ABPH IN 1997-2000

VARSAINAISET JÄSENET		VARAJÄSENET	
Markku Lehto	Kansliapäällikkö	Mikko Hurmalainen	Osastopäällikkö
Jarkko Eskola	Osastopäällikkö, ylijohdaja	Reijo Väärälä	Apulaisosastopäällikkö
Kimmo Leppo	Osastopäällikkö, ylijohdaja	Marjukka Vallimies-Patomäki	Ylitarkastaja
Vilho Hirvi	Kansliapäällikkö	Marja-Liisa Niemi	Ylitarkastaja
Jarmo Hirsto	Hallitusneuvos	Irja Vesanen-Nikitin	Ylitarkastaja
Saara Reinius	Ylijohdaja	Jaana Husu-Kallio	Apulaisosastopäällikkö
Sirkka Hautajärvi	Kansliapäällikkö	Kirsti Vepsä	Neuvotteleva virkamies
Pirkko Lahti	Toiminnanjohtaja	Per-Erik Isaksson	
Eino Heikkinen	professori	Toiminnanjohtaja	pääsihteeri
Leena Soininen	Läänlääkäri	Sakari Karjalainen	
Maija Anttila	Osastopäällikkö	Marjatta Blanco-Sequeiros	Apulaisosastopäällikkö
Kati Myllymäki	Puheenjohtaja	Anna-Ester Liimatainen-Lamberg	Puheenjohtaja
Kaarina Ronkainen	Osastopäällikkö	Atilla Samaletdin	Toiminnanjohtaja
Kalevi Yliniemi	Perusturvajohtaja	Arto Laine	Työterveyshuoltopäällikkö
Berndt Långvik	Johtaja	Anders Almqvist	Erikoislääkäri
Aulis Potinkara	Toimitusjohtaja	Tuula Taskula	Terveystoimen päällikkö
		Liisa Elovainio	Pääsihteeri

25.3.1998
lähtien

APPENDIX 4. (cont.)

KANSANTERVEYDEN NEUVOTTELUKUNNAN ASiantuntijat 1997-200

Tapani Melkas, neuvotteleva virkamies, STM

Jussi Huttunen, pääjohtaja, Kansanterveyslaitos

Vappu Taipale, pääjohtaja, Stakes

Jorma Rantanen, pääjohtaja, Työterveyslaitos

KANSANTERVEYDEN NEUVOTTELUKUNNAN SIHTEERISTÖ 1997-2000

Merja Saarinen, ylilääkäri, STM

Terhi Hermansson, ylilääkäri, STM

Seppo Koskinen, apulaisylilääkäri, Kansanterveyslaitos

Mikko Kautto, tutkija, Stakes

TYÖJAOSTO 1997-2000

Markku Lehto	kansliapäällikkö	STM, PJ
Liisa Elovainio	pääsihteeri	Sosiaali- ja terveysjärjestöjen yhteistyöyhdistys YTY ry
Jarkko Eskola	ylijohtaja, osastopäällikkö	STM/EHO
Jussi Huttunen	pääjohtaja	Kansanterveyslaitos
Kimmo Leppo	osastopäällikkö, ylijohtaja	STM/PAO
Berndt Långvik	johtaja	Suomen Kuntaliitto
Tapani Melkas	neuvotteleva virkamies	STM/EHO

SIHTEERIT

Terhi Hermansson	ylilääkäri	STM/PAO
Mikko Kautto	tutkija	Stakes
Seppo Koskinen	apulaisylilääkäri	Kansanterveyslaitos
Merja Saarinen	ylilääkäri	STM/EHO

OHJELMAJAOSTO 1997-2000

Jussi Huttunen	pääjohtaja	Kansanterveyslaitos	pj.
Maija Anttila	osastopäällikkö	Tehy ry	
Eino Heikkinen	professori	Jyväskylän yliopisto	
Outi Kupiainen	kehittämispäällikkö	Helsingin terveysvirasto	
Pirkko Lahti	toiminnanjohtaja	Suomen mielenterveysseura ry	
Kati Myllymäki	puheenjohtaja	Suomen Lääkäriliitto	
Ritva Passiniemi	kehittämispäällikkö	Suomen Terveystieteiden tutkimuskeskus ry	
Jorma Rantanen	pääjohtaja	Työterveyslaitos	
Juha Teperi	tulosjohtaja	Stakes	
Kirsti Vepsä	neuvotteleva virka- mies	YM	

SIHTEERIT

Mikko Kautto	tutkija	Stakes
Seppo Koskinen	apulaisylilääkäri	Kansanterveyslaitos

TOIMEENPANOJAOSTO 1997-2000

Tapani Melkas	neuvotteleva virkamies	STM/EHO	pj.
Jarmo Hirsto	hallitusneuvos	LM	
Jyrki Kivistö	neuvotteleva lakimies	Suomen Kuntaliitto	
Anna-Ester Liimatainen-Lamberg	puheenjohtaja	Suomen Terveystieteiden Seuran STM ry	
Marja-Liisa Niemi	ylitarkastaja	OPM	
Kerttu Perttilä	projektipäällikkö	Stakes	
Aulis Potinkara	toimitusjohtaja	Sosiaali- ja terveysjärjestöjen yhteistyöyhdistys YTY ry	
Leena Soininen	lääkintöjohtaja	Lapin lääninhallitus	
Harri Vertio	toiminnanjohtaja	Terveystieteiden edistämisen keskus	
Kalevi Yliniemi	perusturvajohtaja	Kajaanin kaupunki	

SIHTEERIT

Terhi Hermansson	ylilääkäri	STM/PAO
Merja Saarinen	ylilääkäri	STM/EHO

SYDÄN- JA DIABETESJAOSTO 1997-2000

Marjatta Blanco Sequeiros	apulaisosastopäällikkö	STM/PAO	pj.
Antti Reunanen	laboratorionjohtaja	Kansanterveyslaitos	vpj
Tor Jungman	toiminnanjohtaja	Suomen sydäntautiliitto	
Tero Kangas	apulaisylilääkäri	Helsingin terveystieteiden keskus	
Matti Uusitupa	professori, johtava ylilääkäri	Kuopion yliopistollinen sairaala	
Kaj Lahti	ylilääkäri	Vaasan terveystieteiden keskus	

Maaret Ilmarinen	projektipäällikkö	Kunnossa Kaiken Ikää -ohjelma
Marjukka Nurmela-Antikainen	rehtori	Joensuun normaalikoulu
Aira Uusimäki	vt. lääninlääkäri	Oulun lääninhallitus
Olli Simonen	neuvotteleva virkamies	Sosiaali- ja terveysministeriö/EHO

SIHTEERIT

Leena Etu-Seppälä	pääsihteeri	Suomen Diabetesliitto
Maire Kolimaa	ylitarkastaja	STM/PAO

YMPÄRISTÖTERVEYSJAOSTO 1997-2000

Jarkko Eskola	ylijohtaja, osastopäällikkö	STM	pj
Risto Aurola	neuvotteleva virkamies	STM	vpj.
Hannele Nyroos	neuvotteleva virkamies	YM	
Matti Aho	apulaisosastopäällikkö	MMM	
Auli Suojanen	erikoissuunnittelija	Elintarvikevirasto / KTM	
Raisa Valli	neuvotteleva virkamies	LM	
Matti Laiho	erityisasiantuntija	Kuntaliitto	
Jouko Tuomisto	professori	Kansanterveyslaitos	
Marjo-Riitta Hämäläinen	johtava hygieenikko	Joensuun kaupunki /Lääkärijärjestöjen (SLL, ELL, SHLL) ympäristöterveyden neuvottelukunta	
Nina Mäki-Petäys	kaupungin eläinlääkäri	Vantaan kaupunki / Kunnallinen päristö- ja Terveystenhoitoyhdistys	
Harri Vertio	toiminnanjohtaja	TEK (Terveysten edistämisen keskus)/YTY Sosiaali- ja terveysjärjestöjen yhteistyöyhdistys ry	

APPENDIX 4. (cont.)

THE MEMBERS, DEPUTY MEMBERS, AND EXPERTS OF THE ABPH 2000-2003

VARSINAISET JÄSENET			VARAJÄSENET		
Markku Lehto	kansliapäällikkö osastopäällikkö, ylijohtaja	STM, pj	Mikko Hurmalainen	osastopäällikkö	STM
Jarkko Eskola			Reijo Väärälä	apulaisosastopäällikkö	STM
Marjatta Blanco			Risto Pomoell	neuvotteleva virkamies	STM
Sequeiros	apulaisosastopäällikkö	STM	Marja-Liisa Niemi	ylitarkastaja	OPM
Vilho Hirvi	kansliapäällikkö	OPM	Irja Vesanen-Nikitin	ylitarkastaja	Liikenneministeriö
Maria Rautavirta	ylitarkastaja	Liikenneministeriö	Taina Aaltonen	eläinlääkintöneuvos	MMM
Jaana Husu-Kallio	osastopäällikkö	MMM	Anita Ahlfors-Friman	ylitarkastaja	YM
Hannele Nyroos	neuvotteleva virkamies	YM	Anna-Liisa Koskinen	kaupallinen neuvos	KTM
Kristian Tammivuori	hallitusneuvos	KTM	Pirkko Lahti	toiminnanjohtaja	Suomen Mielenterveysseura ry
Mikael Ingherg	toimitusjohtaja	Samfundet Folkhälsan rf	Sakari Karjalainen	pääsihteeri	Suomen Akatemia
Eino Heikkinen	professori	Jyväskylän yliopisto	Pekka Kuosmanen	lääninlääkäri	Itä-Suomen lääninhallitus
Leena Soininen	lääninlääkäri	Lapin lääninhallitus	Ritva Passiniemi	kehittämispäällikkö	Suomen Terveydenhoitajaliitto
Maija Anttila	osastopäällikkö	Tehy ry	Hanna Salmenpohja	LL	STHL ry
Pirkko Valtola	LL	Suomen Lääkäriliitto	Arto Laine	työterveyshuoltopäällikkö	Suomen Lääkäriliitto
Kaarina Ronkainen	osastopäällikkö	Kansaneläkelaitos	Gustav Wägar	johtava lääkäri	Kansaneläkelaitos
Kalevi Yliniemi	perusturvajohtaja	Kajaanin kaupunki	Tuula Taskula	sosiaali- ja terveystoimen päällikkö	Peijaksen sairaala
Berndt Långvik	projektijohtaja	Suomen Kuntaliitto	Sirpa Aalto	toiminnanjohtaja	Suomen Kuntaliitto
Liisa Elovainio	pääsihteeri	Suomen Syöpäyhdistys ry			Munuais- ja Siirtopotilaiden Liitto ry
ASIAINTUNTIJAT					
Tapani Melkas	neuvotteleva virkamies	STM			
Jussi Huttunen	pääjohtaja	Kansanterveyslaitos			
Mauno Konttinen	ylijohtaja	STAKES			
Jorma Rantanen	pääjohtaja	Työterveyslaitos			

APPENDIX 5.

SEMINARS AND EVENTS ORGANISED OR PLANNED DURING HEALTH 2015 PROCESS

The information listed here is based on the available documents. Therefore, the list may be partly incomplete.

Title of the seminar (paralleling the preliminary chapters)	Date	Place	Notes
Health promotion and service system / service system as a part of all health arenas	7.5.1999	Stakes	
Health promotion in municipalities	N/A	N/A	The Finnish Healthy Cities Network was used to process this chapter
Health promotion at home and in the neighbourhood (also: socioeconomic disparities in health)	21.-22.9.1998 and 3.5.1999	The MSAH	
Health promotion in childhood	No information	No information	
Health promotion and school	26.5.1999	No information	
Health promotion and working life	25.3.1999	The MSAH	
Health promotion and industry	11.3.1999	No information	
Health promotion after retirement	No information	No information	
Health promotion, consumption and leisure time	12.2.1999 and 28.4.1999	The MSAH	
Health promotion and media	26.5.1999	The MSAH	
Health promotion and NGOs	17.8.1999	RAY	
Health promotion and research	No information	No information	
Health promotion and international cooperation	28.4.1999	No information	

Seminar on Health for all by the Year 2000 - Finnish national programme; what was successful, what has been learned, how to proceed?	21.1.1998	Paasitorni
Future Studio of the Academy of Finland	08/1998	No information
Terve-SOS Fair / promoting HFA21	05/1998	No information
Workshop: The future of preventive social and health policy	18.-19.1.1999	Haikko
Healthy Cities Congress	01/1999	No information
Health for All - HFA21; open seminar	4.5.1999	Paasitorni
HFA21 - Target Workshop	24.8.1999	The MSAH

APPENDIX 6.

LIST OF CONTRIBUTORS OF WRITTEN STATEMENTS IN 2000 (HEALTH 2015)

The information on names and organisations is not in all cases complete because some documents did not offer details e.g. on organisation or a person's position. Some statements were official ones, some representing a personal view. If an institution is mentioned first before a name, it indicates an official statement. In many cases there were no explicit information, so I have interpreted the official – unofficial status based on the content and form of the statement.

1. Etelä-Savon sairaanhoitopiiri / hallintoylihoitaja Kaija Heikura- Kansanen
2. Etelä-Suomen lääninhallitus / osastopäällikkö Esa Ellala, läänin lääkäri Pekka Jousilahti
3. Satu Helin / Jyväskylän yliopisto, terveystieteiden laitos
4. Pekka Järvinen / STM
5. Kela / osastopäällikkö Kaarina Ronkainen, työterveyshuoltopäällikkö Arto Laine
6. Elisa Kantola-Sorsa / HYKS, lasten ja nuorten sairaala, epilepsiayksikkö
7. Irma Kiikkala / Stakes and Mieli maasta ry
8. Anita Kokkola
9. Kotkan sosiaali- ja terveysvirasto / vastaava ylihammaslääkäri Ritva Vanhala
10. Eeva-Leena Laakso / Asikkalan terveyskeskus, terveyskasvatuksen yhteyshenkilö
11. Leena Soininen / Lapin lääninhallitus, lääninlääkäri
12. Bengt-Vilhelm Levón / Arkkitehtitoimisto Levón&Blomqvist
13. Saara Vitikainen / Liikenneministeriö
14. Eeva Tulisalo / Liikuntatieteellinen Seura
15. Lomakotien Liitto ry / Leena Karhu-Westman
16. Lääketeollisuus ry / toimitusjohtaja Jarmo Lehtonen
17. Ylöjärven terveyskeskus / ylilääkäri Ulla Mattelmäki
18. Naiset yhdessä Irti Päihteistä ry / toiminnanjohtaja Helena Palojärvi

19. Omaiset mielenterveystyön tukena keskusliitto ry / puheenjohtaja Ritva Jokinen
20. Oulun seudun ammattikorkeakoulu, Sosiaali- ja terveysalan yksikkö
21. Kari Paaso
22. Arkkiatri Risto Pelkonen
23. Porin terveysvirasto / avoterveydenhuollon johtava lääkäri Esko Karra
24. Pro Mama ry
25. Pääesikunta / Riitta Ruotsalainen, terveydenhuolto-osasto
26. Ravitsemusterapeuttien yhdistys / puheenjohtaja Merja Rastas
27. Työympäristösihteeri Raili Perimäki-Dietrich / SAK
28. Ville Lehtinen / Stakes, mielenterveysyksikkö
29. Suomen Mielenterveysseura
30. Suomen Terveystieteiden tutkimuskeskus STHL / Ritva Passiniemi
31. Stakes / pääjohtaja Vappu Taipale ja projektipäällikkö Kerttu Perttilä
32. Annikka Tapaninen / Stakes ja Pirjo Vesanen / Ympäristöministeriö
33. Suomen Hammaslääkäriliitto / puheenjohtaja Liisa Luukkonen ja toiminnanjohtaja Matti Pöyry
34. Suomen Kätilöliitto / puheenjohtaja Merja Kumpula
35. Suomen Lastenhoitoalan liitto ry / puheenjohtaja Sirpa Salminen ja toiminnanjohtaja Riitta Vehovaara
36. Suomen lähi- ja perushoitajaliitto SuPer / puheenjohtaja Kaarina Muhli ja kehittämisspäälikkö Arja Niittynen
37. Suomen Reumaliitto
38. Suomen Sairaanhoitajaliitto / toiminnanjohtaja Helena Partinen
39. Annikki Savolainen / Tampereen yliopisto, terveystieteen laitos,
40. Teollisuus ja Työnantajat / Kari Kaukinen, laki- ja sosiaaliasiat
41. Terveystieteiden tutkimuskeskus / toiminnanjohtaja Harri Vertio
42. Jouni Tuomi / Seinäjoen Terveystieteiden tutkimuskeskus
43. Työterveyshuollon neuvottelukunta

- 44. Hilikka Ristimäki / Työterveyslaitos, epidemiologian ja biostatistiikan osasto
- 45. Sakari Tola / Varma-Sampo
- 46. Eduskunta / sosiaali- ja terveysvaliokunnan puheenjohtaja Marjatta Vehkaoja
- 47. Jorma Viitanen / Reumaliiton Kuntoutumislaitos, asiantuntijalääkäri
- 48. Jussi Simpura
- 49. Suomen Lukiolaisten liitto / puheenjohtaja Marja Koskela ja pääsihteeri Riku Honkasalo
- 50. Mari Hakkala / Baltic Region Healthy Cities Office, Turku

APPENDIX 7. A DRAFT FOR THE STRUCTURE OF TK21 PROGRAMME

The Advisory Board for Public Health 22.4.1998

BACKGROUND

0. Introduction (2 p.)
 - the objectives
 - the relationship to other important strategic public health projects and programmes
1. TK 2000 programme: implementation and experiences (2 p.)
2. WHO TK21 programme (global and EURO) (2 p.)
3. International review (3 p.)
 - the EU and public health
 - public health programmes in other countries, a directory

CHALLENGES AND OBJECTIVES

4. What do we know about factors affecting health and how can they be influenced by health policy actions? (3 p.)
 - drafting the operational environment
 - general model and emphasis
5. How does societal and environmental changes affect public health? (6 p.)
 - population (aging, immigration, domestic migration), economy, working life, culture (e.g. family, education), technology, physical environment, neighbouring areas (differences in socioeconomic status), healthy groceries
6. The development of public health - present state and future (6 p.)
 - Health in Finland 2000 and Social and Health Review 2000 as attachments
7. Changing public administration and the mechanisms of health promotion (4 p.)
 - map of actors
8. The objectives and focal viewpoints of Finnish health policy in the 21st century (4 p.)
 - values
 - equality and health
 - course of life
 - maintaining functional capacity

SETTINGS OF EVERYDAY LIFE

9. Health promotion in municipalities (4 p.)
 - handbook as an attachment
10. Health promotion at home and in the neighbourhood (4 p.)
11. Health promotion in childhood (3 p.)
12. Health promotion and school (3 p.)
13. Health promotion and working life (3 p.)
14. Health promotion and industry (3 p.)
15. Health promotion after retirement (3 p.)
16. Health promotion and service system (3 p.)
17. Health promotion, consumption and leisure time (3 p.)

- 18. Health promotion and media (3 p.)
- 19. Health promotion and NGOs (3 p.)

Regarding chapters (9)10-19:

- problems – priorities
- ownership – actors – responsibilities
- means, resources and needed actions
- objectives and monitoring
- sanctions – incentives

- handbooks?

IMPLEMENTATION AND MONITORING OF THE ENTITY OF PROGRAMMES

- 20. Implementation and the roles of various actors
 - ABPH, the Ministries, ...
- 21. Monitoring
 - the realisation of policy objectives; general and process goals
 - other objectives?

APPENDIX 8.

POLICY ANALYSIS ON HEALTH 2015

(Ministry of Social Affairs and Health 2001)

This analytical framework is based on the article of Cheung, Mirzaei, and Leeder (2010). Some sections are not applicable and are marked with N/A.

A Accessibility

1. The policy document is accessible (hard copy and online)

Yes, both.

B Policy Background (Source of Health Policy)

1. The scientific grounds of the policy are established

No scientific grounds have been specified. The background and process have been described as follows:

"This was compiled by the Advisory Board for Public Health set up by the Government, representing several spheres of administration, local authorities, the health services, NGOs, unions and professional organizations, and health research. The process involved consultation with specialists, analyses, seminars and group work. Representatives of organizations, and of sectors of government other than the Ministry of Social Affairs and Health, all worked together as equal partners." p. 5

2. The goals are drawn from a conclusive review of literature

No reference to literature is made, except for *"The WHO's most recent global programme and the programme for the European Region were used as a basis for drawing up Finland's new Health 2015 programme."* p. 4

The rationale for goals is not expressed. The graphs (p. 16-20) include scientific references, but it has not been explained why those qualitative and quantitative goals have been selected.

3. The sources of the health policy is explicit

I. Authority (one or more persons, books, scientific articles or sources of information)

Besides WHO, the references regarding graphs, and general description of actors and seminars, no authority or references are mentioned by name.

II. Quantitative or qualitative analysis

The basis for quantitative and qualitative goals have not been specified so based on the information presented in the programme book, it is impossible to say if there has been analysis prior to selecting the goals.

III. Deduction (premises that have been established from authority, observation, intuition, or all three)

WHO, consultations with specialists, analyses, seminars and group work were mentioned at a gen-

eral level, but there is not detailed information of the actors, process, or methods.

4. The policy encompasses some set of feasible alternatives

The policy document does not specify means so it is impossible to analyse the feasibility. The goals are not explicitly reasoned so it is impossible to analyse them from this viewpoint.

C Goals

1. The goals are explicitly stated [The goals are officially spelled out]

Yes. There are eight goals: five goals for different age groups and three common ones.

2. The goals are concrete enough (quantitative where possible and qualitative where not) to be evaluated later

Yes and no. A few targets are concrete, but most of them are not. Evaluation is difficult to analyse, because there are no indicators included and no action plan for implementation or evaluation. For instance, *“Child wellbeing and health will increase, and symptoms and diseases caused by insecurity will decrease appreciably.”* (p. 15) is difficult to evaluate, but *“Accidental and violent death among young adult men will be cut by a third on the level during the late ‘90s.”* (p. 15) may be verified statistically.

3. The goal is clear in its intent and in the mechanism with which to achieve the desired goals, yet does not attempt to prescribe in detail what the change must be.

No. Goals have been written in a clear manner, but the action lines, which may be interpreted as means, are written in passive voice and are mostly very general. There are no indicators or accountable actors defined so it is difficult to analyse this viewpoint.

4. The action centres on improving the health of the population

Yes.

5. The policy is supported by evidence of external consistency in logically drawing a health outcome from the goals and policy outcome

This viewpoint is difficult to analyse, due to lack of given information.

In theory, for instance a line of action *“Cooperation between central and local government, NGOs and industry to support families and better reconcile the needs of families with children with those of working life.”* (p. 23) may be seen to be consistent with *“Child wellbeing and health will increase, and symptoms and diseases caused by insecurity will decrease appreciably.”* (p. 15)

However, the responsible actors and action plan are not included, so it is not possible to evaluate this aspect.

6. The policy is supported by internal validity in logically drawing a health outcome from the goals and policy outcome

It is not possible to analyse the internal validity, because the basis for the goals or action lines have not been explained.

D Resources

1. Financial resources are addressed [there are sufficient financial resources]

- The cost of condition to community has been mentioned

At a disease level: N/A

On population health and national level: the cost of the disorders and events behind the selected goals have not been mentioned.

- Estimated financial resources for implementation of the policy is given

Yes. *"Implementation of the Health 2015 public health programme outlined in this Resolution and attainment of the targets incorporated into it will require a separate FIM 2.5 million allocation in the national budget. This will be needed to prepare, print and distribute information and training material for the various sectors of the administration, to arrange information and training sessions, to pay for project workers, to promote separate projects in programme implementation, monitoring and assessment, and to support the various ministries as they strive to incorporate health considerations more consistently into their own operations."* (p. 34)

- Allocated financial resources for implementation of the policy are clear

Yes. See above.

- There are rewards/sanction for spending the allocated resources on other programmes

No.

2. Human resources are addressed [there is enough personnel]

No.

3. Organisational capacity is addressed [my organisation has the necessary capacities]

No.

E Monitoring and Evaluation

1. The policy indicated monitoring and evaluation mechanisms

No. There are no indicators for monitoring or evaluation written in the document. Implementation is referred to at a general level:

"Implementation of this Resolution will be monitored regularly as part of the overall process of monitoring the activities of the Government and ministries. Attainment of the targets laid down in this Resolution will be evaluated at least through the below, and new action proposed as necessary."

34. *Monitoring comprehensively covering various sectors and levels of government will take place in connection with the Social and Health Report made every four years.*

35. *An external assessment of health promotion structures, resources and activities will be carried out jointly with the WHO in 2001*

36. *An external evaluation of national health policy will be made during the present decade.” (p. 34)*

2. The policy nominated a committee or independent body to perform the evaluation

No, the evaluation will be made by the Government and Ministries.

3. The outcome measures are identified for each of the explicit and implicit objectives

No

4. The data, for evaluation, collected before, during and after the introduction of the new policy

Not addressed in the policy document / N/A

5. Follow up takes place after a sufficient period to allow the effects of policy change to become evident

Yes and no, see E1. The sufficient period is not evaluated further in the policy document.

6. Other factors that could have produced the change (other than policy) identified

Not addressed in the policy document. / N/A.

7. Criteria for evaluation are adequate or clear

No criteria is defined.

F Political Opportunities

1. Cooperation between political levels involved (federal, state, area health) has either worsened or improved

No information available.

2. Support from other sectors (economy, science, justice) has either worsened or improved

No information available.

3. The political climate has either worsened or improved

No information available.

4. Cooperation between public and private organisations has either worsened or improved
No information available.

5. The lobby for the action has either worsened or improved
No information available.

G Public Opportunities

1. The media's interest has either worsened or improved

No information available.

2. The population supports the action

Yes. There has been a extensive group of people, NGOs included, preparing the document and the Finnish citizens appreciate health as an important value.

3. Multiple stakeholders are involved

Yes.

4. Primary concerns of stakeholders recognised and acknowledged to obtain long-term support

A partial yes. Some challenges have been discussed in the document but not in detail or concerning all stakeholders.

5. There is media's interest

No information available.

H Obligations

1. The obligations of the various implementers are specified – who has to do what?

No.

2. The action is part of health professionals' existing duties

Yes.

3. Scientific results are compelling for action

No information on scientific results is specified.

4. Health professional obliged to the population to act in this area

N/A

WORD CLOUD OF THE 100 MOST FREQUENT WORDS IN HEALTH 2015



APPENDIX 10.

HEALTH 2015 KEYWORD FREQUENCY ANALYSIS

(Conjunctions and similar words were excluded, analysis generated by Wordle)

Most hits:

HEALTH 316
LIFE 47
PROGRAMME 47
GOVERNMENT 47
MUST 44
CARE 38
ACTION 36
PUBLIC 34
POLICY/-IES 33
SERVICES 32
PEOPLE 31

Sample of keywords (in alphabetical order):

ACTION 36
ADMINISTRATION 5
ADVERTISING 0
BASED 5
BUDGET 3
BUSINESS/ES 13
COLLABORATION 1
COLLABORATIVE 1
CONSUMPTION 1
COOPERATION 9
COORDINATING 1
COORDINATION 0
ECONOMY 1
EMPLOYEES 1
EVALUATION 4
EVIDENCE 0
HEALTH CARE 24
HEALTH CENTRE 0
HORIZONTAL 0
HOSPITAL 0
IMPLEMENTATION 2
INDICATOR/S 3
INDUSTRY 11
INITIATIVE 2
INSTITUTE/S 3
INSTITUTION/S 2
INTERGOVERNMENTAL 1
INTERNATIONAL 2
INTERREGIONAL 1
KTL 0

LABOUR MARKET 1
LABOUR MARKET ORGANIZATION 1
LOCAL 21
MANAGEMENT 5
MEDIA 4
MEDICAL 0
MEDICINE 1
MINISTER/'S 2
MINISTRY/-IES 20
MONITORING 9
MUNICIPALITY/-TIES/MUNICIPAL 22
NETWORK/S 4
NGOS 9
NURSE 2
OCCUPATIONAL 3
PARLIAMENT 3
PARTIES (AS IN SIDE, NOT POLITICAL) 4
PARTY 0
PERSONNEL 2
PHYSICIAN 2
PLAN 3
POLITICAL 0
POLITICS 0
PREVENTION/PREVENTIVE/PREVENTING 4
PRIMARY 0
PROFESSION 0
PROFESSIONALS 3
REFORM 0
REGION/AL 6
RESEARCH 25
RESEARCHERS 1
RESOURCES 3
SCIENCE 0
SCIENTIFIC 1
SECONDARY 0
STAKES 3
STRATEGY/IES 10
TARGET/S 44
TTL 0
UNIVERSITIES 4
WHO/'S 11